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MEDICARE AMENDMENTS OF 1979

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3990

[Including cost estimate of the Congressional Budget Office]

NOVEMBER 5, 1979.—Ordered to be printed

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MEDICARE AMENDMENTS OF 1979

NOVEMBER 5, 1979.—Ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 3990 which on May 8, 1979, was jointly referred to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3990) to amend certain provisions of title XVIII of the Social Security Act with respect to the medicare program established by such title, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

I. PURPOSE AND BACKGROUND OF THE BILL

As a result of hearings and investigations conducted during the last several years, your committee has come to the conclusion that a number of benefit and administrative improvements in the medicare program are necessary and appropriate at this time. Your committee recognizes that, in addition to the provisions contained in this legislation, a number of other liberalizations in the medicare benefit structure also would be desirable. However, in recognition of the budgetary limitations which prohibit extensive benefit expansions at this time and because of the general concern about the present rapid rate of increase in health

care costs, your committee has provided for only limited improvements in medicare benefits, often making difficult choices between meritorious and deserving alternatives in order to keep this legislation within the increase in medicare outlays that has been included in the congressional budget resolutions for Fiscal Year 1980 in anticipation of the enactment of this bill.

On June 18 and 27 of this year, your committee's Subcommittee on Health conducted two days of public hearings on possible amendments to the medicare program. Included among the various medicare proposals considered during these hearings was H.R. 3990, the Medicare Amendments of 1979 and a number of proposals submitted by the Administration. This bill, as introduced, was identical to H.R. 3097, the medicare bill which was reported by your Committee and approved by the House of Representatives during the 95th Congress but because of time limitations, never acted upon by the Senate. During its deliberations in executive session on September 20, 1979, the Subcommittee on Health developed a number of new medicare provisions, made minor modifications in the provisions in H.R. 3990, as introduced, and included all these provisions in an amended version of H.R. 3990. The provisions in the bill relate to benefit enrollment requirements, general program administration and savings which can be achieved without any loss of protection for beneficiaries. The outlays for new benefits included in H.R. 3990 stay within the scope of the budgetary limitations the committee established in its budget request. The Subcommittee's bill was submitted to the full Committee on Ways and Means on October 19. After two days of consideration of H.R. 3990, October 24 and 30, the full committee ordered it reported, with further amendments.

Your committee fully recommends this legislation, noting that it provides for important benefit expansions as well as for more efficient administrative procedures and cost saving measures, yet recognizes the need for exercising discipline in enacting medicare improvements in light of budgetary limitations. Your committee believes the bill represents an equitable approach to limited program expansion at this time from the perspective of both beneficiaries and taxpayers, but your committee remains committed to continuing its efforts to improve the medicare program as conditions permit.

II. Summary of the Bill

As approved by the Committee on Ways and Means, H.R. 3990 would provide for a number of improvements in medicare benefits including liberalization of the home health benefit; elimination of the second waiting period for reentitled disability beneficiaries; coverage for services furnished in community mental health centers and outpatient rehabilitation facilities; authority for the President to enter into reciprocal agreements with other countries to provide hospital and medical services to medicare beneficiaries while outside the United States; and elimination of the medicare blood deductible. Among other changes are benefit improvements relating to services furnished by dentists, optometrists, chiropractors, and physical therapists.

Your Committee's bill also includes provisions which would improve the administration of the medicare program and reduce the cost of the

program without any loss of protection for beneficiaries. The Secretary would be provided authority to exercise flexibility in the application of medicare standards to rural hospitals and to seek reimbursement from private insurance carriers where there is liability for services incurred as a result of an auto accident. Your Committee's bill would also direct the Secretary to establish additional standards and requirements for home health agencies. In addition, a number of minor provisions in the medicare law relating to administration and enrollment have been modified or, where found to be no longer necessary, eliminated.

III. General Statement

SHORT TITLE (SECTION 1)

This Act may be cited as the "Medicare Amendments of 1979."

HOME HEALTH SERVICES (SECTION 2)

Since the beginning of the medicare program, home health benefits have been available under both part A—hospital insurance—and part B—medical insurance.

To be eligible for home health care, the beneficiary must be: (1) essentially confined to his home, (2) under the care of a physician, and (3) in need of skilled nursing care, speech therapy, or physical therapy. If all these requirements are met, an individual is eligible for the full range of home health services.

The bill would liberalize the medicare home health benefit in the following manner: (1) unlimited visits would be available under both parts A and B; (2) the present three-day prior hospitalization requirement under part A would be eliminated; (3) home health benefits under part B would no longer be subject to the $60 deductible; (4) the need for occupational therapy would be included as one of the qualifying criteria for the home health benefit; and (5) the present requirement that proprietary home health agencies can participate in medicare only in those States that license home health agencies would be eliminated. In addition, the bill would establish additional standards and reimbursement guidelines for the effective administration of the home health benefit.

Elimination of the limits on the number of visits under parts A and B.—Beneficiaries are presently eligible for 100 visits per benefit period during the year following a hospital stay of at least three days under part A and 100 visits per calendar year under part B. Your Committee's bill would eliminate the limitation on visits under each part.

Elimination of the three-day prior hospitalization requirement under part A.—In order to receive home health benefits under part A, beneficiaries must be hospitalized for at least three consecutive days. Elimination of this requirement would be particularly helpful to the more than 1.1 million beneficiaries who have only part A of medicare; presently they do not have access to the home health benefit unless they have met this prior hospitalization requirement.

Elimination of the part B $60 deductible with respect to home health services.—In 1972, legislation was enacted which exempted the

part B home health benefit from the 20-percent coinsurance applicable to other part B services. Elimination of the part B $60 deductible with respect to such services would eliminate the remaining patient cost-sharing on home health services.

Addition of the need for occupational therapy as one of the criteria qualifying a beneficiary for home health benefits.—Under present law, only the need for skilled nursing care or speech or physical therapy qualifies a beneficiary for home health benefits; occupational therapy services are available as a home health benefit only after the beneficiary has otherwise qualified. Occupational therapy, like physical therapy or speech therapy, is a skilled health service which assists a patient who is recovering from an illness or injury in making the transition between an institution and self-care in the home. Accordingly, your Committee's bill recognizes occupational therapy as the fourth skilled service which will qualify beneficiaries for the home health benefit.

Elimination of the licensing requirement for proprietary home health agencies.—By law, proprietary, or for-profit, home health agencies are eligible to participate in the medicare program only where the agency is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed in regulations. Since only 24 States presently license home health agencies, there are a number of States in which proprietary agencies are precluded from participating in the medicare program. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service. This provision would eliminate the special licensing requirement under medicare pertaining to proprietary home health agencies and the authority of the Secretary to establish additional standards solely on the basis of the tax status of the agency.

In addition to the liberalizations in the home health benefit, your Committee's bill also includes several provisions to assure the more efficient and economical administration of the benefit.

Regional intermediaries for home health agencies.—The Committee bill requires the Secretary to establish regional intermediaries for home health agencies. The Committee has found a wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers. This is largely attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider. As a consequence, little expertise is developed in this area and there is no way of making meaningful comparisons of the utilization and cost of various agencies. Consolidation of the medicare home health business among a smaller number of intermediaries would enable intermediaries to focus more resources on the administration of the benefit and develop uniform cost and performance criteria.

Your Committee's bill provides that, in the case of those hospital-based home health agencies which use the same medicare intermediary used by their affiliated hospital, the Secretary is to reassign the home health agency to another intermediary only where he determines such

a reassignment would result in more effective and efficient administration of the program.

Home health aides.—The Committee bill modifies the present provision of the home health benefit which covers services furnished by a home health aide on a part-time or intermittent basis by requiring that such aides meet certain qualification standards. It has come to the attention of the Committee that, in some cases, aides have been used to provide services under the medicare home health benefit who have no prior training or experience in caring for the medical needs of the aged and disabled. This has been found to be particularly true in the case of some agencies which do not directly employ home health aides, but contract out for those services, sometimes with personnel agencies which supply general temporary help. The Committee bill makes it clear that home health aides, whether employed directly by the home health agency or made available through contract with another entity, must have completed a training program approved by the Secretary.

Physician certification.—The Committee bill requires that the physician who performs the required certification with respect to home health services and establishes and reviews the plan of treatment cannot be a physician who has a significant ownership interest in or a significant financial or contractual relationship with the home health agency that is providing the service to the medicare beneficiary.

The Committee has found that some home health agency patients have had their certifications or plans of treatment signed and authorized by physicians who are medical directors or owners of the provider home health agencies. The Committee bill would prevent potential conflicts of interest from arising as part of the certification and plan of treatment process.

Bonding and escrow requirements.—In settling the medicare cost reports after the close of a home health agency's fiscal year, it is sometimes determined that in making interim payments throughout the year the medicare program has substantially overpaid the agency. Since home health agencies are generally established with very little capital investment and have little or no equity, there may be no financial resources available to repay the medicare program. For example, in the case of an agency which serves only medicare beneficiaries, the agency can borrow funds to repay the overpayment and medicare will reimburse the agency for 100 percent of the costs related to the loan.

Your Committee believes that, as in the case with agencies which receive all or a substantial portion of their income from the medicare program, it is not in the best interest of the medicare program to totally or almost totally finance a loan to repay itself. Accordingly, your Committee's bill provides the Secretary authority to establish bonding and escrow requirements for such agencies in order to assure the availability of funds to repay any overpayments. Medicare would not recognize as allowable costs for reimbursement purposes any costs which are incurred in connection with meeting the bonding requirement or establishing an escrow account. To assure that the restricted funds are used to make the repayments, medicare would not recognize as allowable costs, any costs or interest charges incurred in connection

with amounts borrowed for the purpose of repaying overpayments. (This limitation on borrowing expenses would apply only to agencies subject to the bonding and escrow requirements.) Your Committee recognizes, however, that the amounts available from the bond or the escrow account may not be sufficient to repay the entire amount of the overpayment. In cases where the restricted amounts are used but are insufficient, the borrowing costs would be recognized as allowable costs, to the extent they are reasonable.

Limitations on reimbursement for certain types of contracts.—The bill provides that, in the case of contracts entered into after the date of enactment under which services are furnished for or on behalf of the agency, no costs incurred by the agency in connection with such a contract would be considered allowable costs if either (i) the term of the contract exceeds five years, or (ii) the amount payable under the contract is based on a percentage of the agency's reimbursement for services furnished.

The General Accounting Office has concluded that long-term contracts, as long as—20 to 30 years—which typically provide for management consulting services, are a source of abuse in the medicare program. Similarly, franchise operations have been identified which base their fees on a percentage of reimbursement, with the result that payment under the contract may be considerably more than the actual value of the services furnished. This provision would require the home health agencies to follow normal prudent business practices and assure that the program would not have to pay excessive costs.

With respect to existing percentage-of-reimbursement contracts for services, your Committee's bill would limit medicare reimbursement to amounts which are equal to the reasonable value of the service. In adapting these limitations on reimbursement for existing percentage contracts of home health agencies, your Committee intends in no way to diminish any of the Secretary's authority, under current law, to impose limitations on the costs that will be recognized as allowable with respect to contracts entered into by providers of services.

Other administrative requirements.—The Committee bill authorizes the Secretary to establish such other administrative requirements for home health agencies as he finds necessary for the effective and efficient operation of the program. It is the Committee's intent to provide sufficient direction to the Secretary to insure the development of more adequate administrative and reimbursement guidelines and, at the same time, provide the Secretary with authority to establish such additional guidelines or requirements he deems necessary in order to improve the administration of the program. In particular, the Committee expects the Secretary to take the following actions:

Develop and promulgate under the authority of section 223 of Public Law 92–603, where appropriate, limits on specific categories of costs incurred by home health agencies; such limits would be in addition to those overall per visit limits which may already be in effect;

Develop and issue to fiscal intermediaries by July 1, 1980, cost screens which are to be used by the intermediaries in determining whether an agency's overall costs or costs in specific categories are substantially out of line with those of comparable home health agencies;

To develop and issue to the fiscal intermediaries by January 1, 1981, detailed utilization screens which can be used for both reimbursement purposes and identifying potential program abuse;

Develop appropriate mechanisms for assuring that the present standards related to the supervision of home health aides by nurse supervisors are enforced; and

Conduct a comprehensive demonstration program to evaluate alternatives to the present cost reimbursement method for home health services, and to report back to the Committee on the progress and findings of the demonstrations by January 1, 1981, and annually thereafter.

ELIMINATION OF THE SECOND WAITING PERIOD FOR REENTITLED DISABILITY BENEFICIARIES (SECTION 3)

Under your Committee's bill, entitlement to medicare benefits would be provided for individuals who have been entitled to disability payments for a total of 24 months, regardless of whether those 24 months were consecutive. In that way, an individual who has satisfied the 24-month requirement and attempts unsuccessfully to return to work would be immediately entitled to medicare benefits. Medicare coverage would also be extended for an additional 36 months to disability beneficiaries who return to substantial gainful work.

Medicare protection is provided for individuals after they have been receiving social security cash benefits on the basis of disability for 24 consecutive months. Should a beneficiary recover sufficiently to engage in gainful employment, his disability cash benefits and his medicare coverage are terminated. If the individual becomes disabled a second time within 5 years, he immediately regains entitlement to cash disability benefits, but he must once again satisfy the 24-month waiting period requirement to qualify for medicare protection.

The purpose of eliminating a second 24-month waiting period for reentitlement to medicare benefits and providing an extended period of entitlement to such benefits for those who return to work, is to encourage disabled persons to attempt to return to work if their conditions improve, without fear of forfeiting protection against medical expenses. Moreover, there is concern that the waiting period provision works an undue hardship on those individuals who try, but are unsuccessful, in their attempts to return to gainful employment.

RECIPROCAL AGREEMENTS FOR COVERAGE OUTSIDE THE UNITED STATES (SECTION 4)

The bill authorizes the President to enter into reciprocal agreements with other countries to provide hospital and medical benefits for medicare beneficiaries living or traveling outside the United States.

Under present law, medicare coverage is provided, with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous states and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexi-

can hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions, and determining the appropriate amount of payments to make for services.

A significant number of medicare beneficiaries are deprived of their medicare benefits during such times as they may be traveling or living outside the United States. Since the basis of the limitation in present law is administrative, your committee believes that considerations of equity dictate the development of a reasonably workable arrangement for assuring medicare protection, to the extent feasible, for such beneficiaries.

Your committee recognizes that there are limitations in the approach included in the bill to providing coverage outside the United States. The negotiation process is likely to be time-consuming (although the bill provides authority, pending the conclusion of an agreement, for the Secretary to enter into interim arrangements with accredited hospitals in a country if srious negotiations are in progress), and there is the possibility that some countries will choose not to enter into an agreement. Moreover, the bill includes certain restrictions on the authority to negotiate such agreements. For example, no reciprocal agreement negotiated under the authority granted by the bill may provide entitlement to benefits in the United States for foreign nationals who do not meet medicare's entitlement requirements with respect to age or medical condition (regardless of that individual's status under his country's program), or authorize any individual to receive benefits in the United States on a reciprocal basis in excess of those benefits provided for medicare beneficiaries. Nevertheless, your committee believes that the use of reciprocal agreements represents the most effective method at this time to begin to overcome the administrative and technical obstacles that have heretofore precluded any coverage for services furnished to beneficiaries while they are outside the United States.

DENTISTS' SERVICES (SECTION 5)

The bill would modify present law to cover services performed by dentists where those services are presently covered when performed by physicians. The bill would also cover hospital stays for the performance of noncovered dental services where the severity of the dental procedure warrants hospitalization.

Under present law, services furnished by dentists are covered under part B of medicare but only with respect to: (1) Surgery of the jaw or any structure contiguous to the jaw, or (2) reduction of any fracture of the jaw or facial bone. Payment for routine dental services is specifically excluded. However, there are some services which are regularly performed by both physicians and dentists but which are covered under medicare only if performed by a physician. For example, certain procedures and services relating to treatment of oral infections are covered when furnished by a physician but are not covered when furnished by a dentist. Such functions do not involve routine dental care, which is separately excluded under existing law whether performed by a dentist or a physician. It is your Committee's

belief that it would be appropriate to provide the same coverage for services performed by a dentist (which are within the scope of his state license) that is provided for services performed by physicians. The present exclusion of routine dental services would remain in effect.

Your Committee also concluded that present coverage for inpatient hospital services related to certain noncovered dental procedures is inadequate. Under existing law, the test for medicare coverage of the inpatient services is the patient's underlying condition (e.g., history of heart failure). As a result, hospitalization coverage is precluded where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization. Accordingly, your Committee's bill would cover hospital stays based on a dentist's (or physician's) certification that hospital inpatient services are necessary for the performance of noncovered dental procedures either because of the severity of the dental procedure or the patient's underlying condition warrants such hospitalization.

TREATMENT FOR PLANTAR WARTS (SECTION 6)

Your committee's bill would eliminate the present exclusion of services related to treatment of plantar warts.

Under present law, coverage for services related to routine foot care—which is defined as "including the cutting and removal of corns, warts, or calluses, trimming of nails, and other routine hygienic care"—is specifically excluded.

Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service. Your committee is concerned about this inconsistency in present law and the committee bill therefore eliminates the present exclusion on coverage of services related to the treatment of plantar warts.

COMMUNITY MENTAL HEALTH CENTERS (SECTION 7)

The bill provides that services furnished in qualified community mental health centers would be reimbursed under part B of medicare on a cost-related basis or on the basis of other tests of reasonableness as are determined by the Secretary to be appropriate. Up to fifteen outpatient visits per year would be covered and up to 60 partial hospitalization visits per year would be covered.

Community mental health centers are not specifically recognized under present law. Services furnished by a community mental health center which is physician-directed are presently covered either as physicians' services or services furnished "incident to" a physician's services (e.g., services of psychologists and other professionals). Services furnished in community mental health centers which are not physician-directed are not generally covered under the medicare program.

Since 1963, the Federal Government has been involved in efforts to develop community mental health centers which offer a range of outpatient mental health services in the expectation that such centers would replace large inpatient institutions as the primary place of

treatment for the mentally ill. Your committee believes that the current medicare limitations on the coverage of outpatient mental health services are not consistent with this larger objective.

Your committee recognizes that there are differences within the health care community as to the strict applicability of the medical model to the diagnosis and treatment of mental disorders. Thus, while standard medicare terminology may be used for definitional purposes in the bill, your committee intends that this terminology be understood and applied within the framework of accepted prevailing practices followed by qualified community mental health centers in the provision of mental health services. It is also the intent that periodic review and approval of a plan of treatment be conducted by a center's duly constituted treatment review committee, of which the physician is a member, composed of members of the several disciplines involved in the care and treatment of the patient. In addition, while the physician certification with respect to partial hospitalization visits must include a judgment as to the patient's need for institutionalization in the absence of partial hospitalization visits, it is not the intent that such a judgment need imply that institutionalization would otherwise be required immediately.

The use of the term "diagnostic and therapeutic services" in the definition of covered community mental health services is intended to also encompass those liaison and coordination services furnished by qualified mental health personnel of the center as part of the overall management of patient care. Also, the term "under the case management of a physician" in the community mental health center setting is used to emphasize that daily, "over-the-shoulder" supervision by a physician of all of the services furnished by the center is not appropriate.

Case management is intended to imply a process through which a physician and qualified mental health professionals collaborate in order to ensure equality of patient care and treatment. Case management requires that the physician monitor and evaluate all medicare patients, be available for advice and consultation as needed, and provide direction and supervision to the qualified mental health professionals concerning the medical services to be provided. This process may take place apart from the direct service contact of the qualified mental health professional. This process must also be regularly scheduled, depending upon the patient's condition, and documented in the patient's record.

Your Committee's bill would extend recognition as qualified providers only to those centers meeting the definition of and requirements for a community mental health center contained in the Community Mental Health Center Act and the regulations prescribed thereunder. However, the bill directs the Secretary to develop comparable standards, in consultation with appropriate professional organizations, (including the Joint Comission on Accreditation of Hospitals), for the possible future coverage of other outpatient mental health centers, and to submit to the Congress such recommendations as he finds appropriate with respect to coverage and standards for such centers. Such recommendations are to be submitted within 24 months after enactment.

COMPREHENSIVE OUTPATIENT REHABILITATION CENTERS (SECTION 8)

Comprehensive outpatient rehabilitation centers would be recognized under your committee's bill as providers of services under medicare. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction diagnostic, therapeutic, and restorative services to outpatients and would be required to meet specified conditions of participation.

Under present law, medicare covers certain rehabilitation services in a variety of settings under various coverage provisions. Such services are included among the services that may be reimbursed on a charge basis as "incident to" the services of a physician. Outpatient physical therapy and outpatient speech pathology services are covered on a cost-related basis when furnished by a clinic, rehabilitation agency or public health agency; however, this coverage provision does not include occupational therapy and other rehabilitation services. Services furnished by an independently practicing physical therapist in the office setting are also covered, but there is an annual limit on the amount medicare will pay for such services.

Present law does not provide coverage for a broad array of rehabilitation services where these are furnished on an outpatient basis in a coordinated fashion by a comprehensive outpatient rehabilitation facility. Your committee's bill would make provision for such coverage, including the coverage of occupational therapy, by recognizing such facilities as providers of services if they meet specified conditions of participation and by providing reimbursement under part B for the services ordinarily furnished by such facilities based on the costs they incur in furnishing covered services to medicare beneficiaries.

OPTOMETRISTS' SERVICES (SECTION 9)

Your Committee's bill would provide coverage for services furnished by optometrists to aphakic patients (patients without the natural lens of the eye). Also, the Secretary would be directed to report to the Congress as to specific legislative recommendations for implementing coverage for services furnished by optometrists to cataract patients.

Present law specifically excludes payment for eyeglasses, eye examinations for the purposes of prescribing, fitting, or changing eyeglasses, and procedures performed to determine the refractive state of the eye. However, post-surgical lenses for aphakic patients are covered as prosthetic devices when prescribed by a physician or an optometrist. While medicare will cover the cost of a physician's examination to determine the need for the prosthetic lenses, the cost of the same service when furnished by an optometrist is not covered. The only serivces for which optometrists may be reimbursed under present law are dispensing services in connection with the actual fitting and provision of such prosthetic lenses.

A study was conducted by the Department of HEW in 1976 to determine the appropriateness of medicare coverage for services furnished by optometrists. They expert consultants to the study concluded that medicare coverage should be extended to those services that an optometrist is legally authorized to perform in connection with the

treatment of aphakia and cataracts. However, HEW recommended that, while optometrists' services related to aphakia should be covered at the present time, it would be inappropriate to provide coverage for services furnished by optometrists to cataract patients until the Department has had an opportunity to resolve a number of administrative issues related to such matters as delivery pattern changes, utilization controls, an operational definition of cataracts, and cost controls. In light of these considerations, your committee's bill provides for the coverage of optometrists' services to aphakic patients and directs the Secretary to complete his analysis of the pending administrative issues and submit legislative recommendations with respect to medicare reimbursement for optometrists' services for cataract patients.

ANTIGENS (SECTION 10)

The bill would allow payment to an allergist for the preparation of a reasonable supply of an antigen, including a supply forwarded to another physician or a rural health clinic for administration.

Under present law, medicare coverage of drugs and biologicals (including antigens) is limited to those drugs and biologicals which (a) cannot be self-administered, (b) are commonly furnished in physicians" offices incident to a physician's professional service, and (c) are commonly either rendered without charge or included in the physician's bill. Thus, the cost of antigens can be covered, but only where their preparation and administration is an integral part of the allergist's service and represents an expense to him. Your Committee's bill would allow payment to an allergist for the preparation of a reasonable supply of antigen, including a supply forwarded to another physician or a rural health clinic for administration.

In the case of a beneficiary who lives some distance from his allergist, the allergist diagnoses the patient's allergy and prepares an antigen with which to treat it; and often, the patient's family physician performs the actual administration of the antigen. Under present law, however, the cost of the antigen is not covered unless the allergist who prepared the antigen also administers it. This creates a financial hardship for a beneficiary who lives too far from his allergist to travel back and forth for the regular administration of the antigen, since he must pay for the antigen himself. Your Committee's bill would remedy this problem by allowing payment for the antigen even where the allergist does not administer it.

PAYMENT WHERE BENEFICIARY IS NOT AT FAULT (SECTION 11)

Your committee's bill requires the Secretary to make payment where a medicare beneficiary who medically required a higher level of care was erroneously placed in a distinct part of an institution designated to offer a lower level of care.

Under present law, a hospital may designate a "distinct part" of its facility (i.e., an entire, physically identifiable unit consisting of all the beds in that unit, such as a separate building, a floor, ward or wing) and have it qualify for participation in medicare as a skilled nursing facility. Patients located in the "distinct part" skilled nursing facility are entitled to skilled nursing facility benefits, but not hospital benefits. (The purpose for permitting such distinct parts is

to assure ease of transfer while maintaining continuity of medical supervision for patients who no longer require hospital services but do require skilled nursing facility care.)

A skilled nursing facility may similarly designate a "distinct part" which participates in medicare as a skilled nursing facility, whle the remaning part of the institution serves as a nonparticipating domiciliary or intermediate care facility. Only patients located in the participating skilled nursing facility distinct part are entitled to medicare skilled nursing facility benefits.

There have been instances in which a patient who requires inpatient hospital services has been inadvertently or erroneously placed in a bed in the skilled nursing facility distinct part of the hospital as a result of a professional or administrative error in judgment. In such cases, the beneficiary's claim for medicare hospital benefits has been denied. Similarly, there have been instances in which nursing home patients have been placed, on the basis of erroneous professional or administrative judgments, in beds in the nonparticipating part of the facility, thus depriving them of their entitlement to skilled nursing facility benefits. In neither case of this type is the beneficiary in a position to make a choice or influence the action taken by the facility or hospital.

Your committee is concerned that under present law beneficiaries must bear the adverse consequences resulting from erroneous professional judgments as to the appropriate level of care required and erroneous or inadevertent provider administrative actions in the placement of a patient. Accordingly, the committee's bill requires the Secretary to make payment in such situations—on a case-by-case basis—where he determines that the beneficiary medically required the higher level of care that should have been provided. Thus, payment would be made under this provision where the erroneous transfer was caused by: (1) An action of a utilization review committee, a professional standards review organization, a fiscal intermediary, or (2) a provider of services which, acting in good faith, inadvertently or erroneously assigned the patient to the wrong bed.

It is the committee's intent that this authority to provide payment for certain noncovered services be used in appropriate cases only; that is, where it is clear that an error has been made. It is expected that the Secretary will take all necessary steps to assure that this provision is not abused.

FLEXIBILITY IN APPLICATION OF STANDARDS OF RURAL HOSPITALS (SECTION 12)

The bill authorizes the Secretary to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which if rigidly applied would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under present law, to participate in medicare, a hospital must satisfy certain statutory conditions of participation relating to health and

safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretry is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. (Many requirements relating to fire and safety precautions have been promulgated in accordance with this regulatory authority.) Until December 31, 1978, authority existed for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital where he determined the hospital was making a good faith effort to comply with the 24-hour requirement but such compliance was impeded by a lack of qualified nursing personnel in the area.

Many professional people contend that medicare's health and safety standards are designed primarily for large urban hospitals and that, consequently, the rigid application of these standards to rural hospitals, many of which provide a lesser range of services and have limited access to the services of technical personnel, creates unnecessary financial and management burdens. While your Committee does not share the view that different or lesser standards ought to be applied to rural hospitals—since the intent of requiring compliance with basic standards is to uniformly assure the safety and quality of care for all patients—your Committee does believe it is necessary to provide for some flexibility in the application of national standards. Such flexibility, however, would be permissible only to the extent that it does not jeopardize or adversely affect the health and safety of patients.

Under this provision of your Committee's bill, it would still be necessary for the Secretary to assure that there is compliance with appropriate quality and safety requirements. For example, with respect to the requirements for nursing services, the Secretary could provide for a temporary waiver of the requirements but only for such period as he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area, a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift, and the employment of such nursing personnel as are available to the facility during such temporary period would not adversely affect the health and safety of patients. Similar tests are to be applied by the Secretary with respect to other types of technical personnel, including tests related to the scope of services furnished by the facility and the facility's good faith efforts to fully comply with personnel requirements. The underlying premise, however, is that the Secretary will exercise the authority herein granted to apply standards with some flexibility only when he is satisfied that the health and safety of patients will not be jeopardized and that those services rendered by the affected facilities are delivered in a manner that is consistent with reasonable standards for such facilities.

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS (SECTION 13)

Under the bill, podiatrists, acting within the scope of their practice, would be recognized by medicare for purposes of physician certification and participation as physicians in utilization review. This recognition would be extended where consistent with State law and the policies of the health care institutions involved.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requiries that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

Since medicare covers as "physicians' services" the services performed by podiatrists within the scope of their practice, your committee concluded that medicare should also recognize podiatrists as physicians for purposes of physician certification and participation in utilization review.

The bill extends this recognition to certification and utilization review activities that are consistent with the functions the podiatrist is legally authorized to perform in the state where he practices, and where this recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilization review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY SERVICES (SECTION 14)

The bill would repeal the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished.

Since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, your Committee's bill allows either the physician or the speech pathologist to establish the plan of treatment so as to conform to medicare law and related program policy to actual practice among the professions. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED (SECTION 15)

The bill would authorize medicare reimbursement for physicians' services rendered to a medicare patient before his death, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physician's services.

Under present law, a beneficiary who has received physician services which are reimbursable under medicare can either: (1) Send medi-

care an itemized bill, whether paid or unpaid, and be reimbursed directly by the program, or (2) assign the right to receive payment to the physician who provided the service. Where a beneficiary dies before he has executed an assignment of the bill, payment may be made directly to the physician only if he agrees to accept the medicare-determined reasonable charge as payment in full. (He may collect from the beneficiary only the applicable deductible and coinsurance amounts.) If the physician does not agree to this procedure, present law authorizes medicare reimbursement to the estate or the survivors of the deceased beneficiary, but only if the bill has been paid.

Your committee believes that the requirement that the physician's bill must be paid (where the assignment method is rejected by the physician) before medicare can make reimbursement often represents a significant financial burden for survivors of the deceased beneficiary. Thus, in cases where a physician does not agree to accept assignment on a claim for payment of services furnished to a deceased beneficiary, your committee's bill would allow payment on the basis of an unpaid bill. Payment would be made only to an individual who presents evidence that he has assumed the legal obligation to pay for the physician's services.

PRESUMED COVERAGE PROVISIONS (SECTION 16)

The bill would repeal existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by general waiver of liability provision.

The 1972 social security amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. And in practice, the regulations carrying out this provision create unnecessary administrative steps for both providers and the program since the problem of retroactive denials has been ameliorated by other means. Another provision of the 1972 amendments—a more general waiver of liability—has turned out to be a more effective remedy and the presumed coverage provisions are no longer needed. (Your Committee notes that, according to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent less than one-half of one percent of all claims for payment filed by these providers.)

It is your Committee's intention that since the waiver of liability provision is to be used in all cases in this area, its rules are to be applied flexibly so as not to work undue hardship in cases which had been covered under the presumed coverage approach. In particular, it is intended that care be used in the application of rigid percentage limi-

tations with respect to acceptable denial rates. This is particularly true in the case of those providers of service that have very small numbers of medicare beneficiaries where a denial in one or two cases might have the effect—through strict application of a percentage formula—of denying access to the favorable presumptions embodied in the provision.

PAYMENT TO PROVIDERS OF SERVICES (SECTION 17)

The bill would repeal the existing provisions of the medicare law under which payments to a provider of services are limited to the provider's customary charges if these charges are lower than reasonable costs.

Also, medicare reimbursement to providers of services under part B would be based on reasonable cost minus the coinsurance amounts charged beneficiaries by the provider.

Although medicare providers of services are generally reimbursed, under present law, on the basis of reasonable costs, the amount of payment is limited to the lesser of the reasonable cost of covered services or the provider's customary charges to the public for such services. A variation of this rule applies to "public" (i.e., governmental) providers of services who render services free of charge or at nominal charges to the public; such providers are reimbursed, pursuant to regulations of the Secretary, on a basis that provides fair compensation. The rationale for this lower of costs or charges provision was that it would be inequitable for medicare to pay more for services than the provider charges the general public. However, despite an elaborate set of rules to avoid harsh treatment of certain providers, situations have arisen in which there is a question whether it is good public policy reduce reimbursement, as this provision requires, to levels below cost—for example, in the case of Easter Seal rehabilitation agencies and community-supported home health agencies. Accordingly, the bill would repeal the lower of costs or charges provision.

Under another provision of present law, providers of services are paid 80 percent of the reasonable cost for services covered under medicare part B. Providers are authorized to charge beneficiaries a coinsurance amount equal to 20 percent of the reasonable charges (not in excess of their customary charges) for the services in question. The medicare reimbursement amount and the coinsurance amount are determined without reference to each other. Together, they sometimes produce income to the provider in excess of 100 percent of the reasonable cost. This result would be avoided under your committee's bill, which provides for payment of 80 percent of the reasonable cost only to the extent that this does not exceed the reasonable cost minus the coinsurance.

LIMITS ON PREMIUM INCREASES DUE TO LATE ENROLLMENT (SECTION 18)

The bill would modify the existing provisions that require premiums for medicare part B (and for optional part A coverage) to be increased by ten percent for each year the beneficiary could have been but was not enrolled by limiting the premium increase to a maximum of 30 percent.

Under present law, if an individual fails to enroll timely in medicare's medical insurance plan (part B), the otherwise applicable premium amount is increased by 10 percent for each 12 months elapsing between the time he could have enrolled and actually did enroll. A similar premium increase is charged to uninsured persons who do not enroll timely in the hospital insurance plan (part A). There is no limit on the percentage amount the part A or part B premium can be increased due to late enrollment. The purpose of these provisions was to avoid the adverse selection that might occur if substantial numbers of healthy persons delayed enrollment until they were well past age 65 and became ill.

Most people, your committee has found, who enroll late do so, not because their health has deteriorated, but for a variety of reasons not related to health. For example, many aged beneficiaries mistakenly believe they have to retire from work before they can enroll and thus enroll long after their initial enrollment period. Others, who are residing outside the country and cannot benefit from part B because of the exclusion of foreign medical care, enroll only upon their return to the United States. Still others decide not to enroll initially because they are covered under their employers' or their spouses' health plan. In many of these cases, the increased premium due to late enrollment could be considerably higher than the expected increase in program costs resulting from late enrollment and, in some cases, could produce a total premium that is prohibitive to persons living on reduced retirement income. The committee bill establishes a 30 percent limit on the amount by which parts A and B premiums can be increased due to late enrollment. Such a limit should keep the premium within more affordable reach and yet deter such adverse selection as might still occur.

REENROLLMENT IN PART B (SECTION 19)

The bill would repeal the provision of existing law that permits an individual to reenroll in part B only once.

Under present law, an individual is permitted to reenoll in part B of the program only once; that is, if he disenrolls twice he is permanently barred from participation in the program. While the original purpose of this provision was to prevent the adverse selection that could occur if individuals were permitted to enroll and disenroll at will whenever there was a change in their health condition, your committee has found that beneficiaries do not as a rule disenroll from the program without good reason. But, there have been instances in which individuals through misunderstanding or inadvertence, have barred themselves from the program. Accordingly, your committee's bill allows unlimited reenrollment in part B while retaining the present provision relating to the time of the annual open enrollment period. Elimination of this part B requirement would also allow unlimited reenrollment under part A.

CHIROPRACTORS' SERVICES (SECTION 20)

This bill would modify the requirements for chiropractic coverage so that a subluxation could be demonstrated to exist either through X-ray or other chiropractic clinical findings. An X-ray, where taken to diagnose a subluxation, would be covered by medicare.

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by X-ray; however, the cost of the X-ray is not covered when performed by a chiropractor.

The X-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an X-ray. The General Accounting Office has indicated that the extent to which X-rays play a part in claims denial is not known. Although chiropractors must have X-rays available upon request, the X-ray is actually reviewed by medicare carriers in only a small number of cases.

Your Committee believes that the requirement for an X-ray to demonstrate the subluxation of the spine is not necessary in every case, is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take X-rays in every case to diagnose subluxation of the spine, your Committee has concluded that it is inappropriate to require X-rays, with their accompanying radiation risks, for administrative purposes. Your Committee also believe that it would be appropriate to pay for an X-ray where it is a necessary part of the chiropractor's diagnosis.

OUTPATIENT MENTAL HEALTH SERVICES (SECTION 21)

The bill would increase reimbursement for outpatient mental health services from the present limit of 50 percent of reasonable charges, up to $250 in actual program payments per year, to 80 percent of reasonable charges, up to $750 in program payments per year. Services furnished by clinical psychologists on an outpatient basis would be covered, subject to the overall limit on outpatient mental health services, where the patient is referred by a physician.

Your Committee believes that the present limitation on payment for mental health services, which has been in effect since the enactment of the program in 1965, is no longer realistic because of the substantial increase in the cost of health care services since that time. Increasing the limit on program payment to 80 percent of reasonable charges, up to $750 per year, would substantially increase beneficiary protection.

Outpatient mental health services would also be made more available to the elderly by covering the services of qualified clinical psychologists. The bill defines a qualified clinical psychologist as one who is licensed in the State (or in a State which does not license clinical phychologists, is legally authorized to perform the services of a clinical psychologist) and meets such other requirements determined necessary by the Secretary. It is your Committee's intent that a qualified clinical psychologist would be further defined by the Secretary as an individual who has a doctorate degree in psychology and has had at least two years of supervised clinical experience in an organized setting such as a hospital which has an accredited mental health facility or a Federally-qualified community mental health center, or who has a comparable combination of education and clinical experience. The Committee expects the Secretary to use, to the extent appropriate, the

National Register of Health Service Providers in Psychology which has been established under the auspices of the American Psychological Association. In addition, your Committee expects the Secretary to designate further what specialty training within the various areas of applied psychology would be appropriate for providing therapeutic services to medicare beneficiaries.

The Committee bill would cover outpatient services furnished by independently practicing psychologists only where the beneficiary has been referred to the psychologist by a physician. Your Committee recognizes that there are conflicting views as to the need for and appropriateness of such a requirement. The Committee believes, however, that such a requirement should be retained until sufficient information is available to evaluate the effect of its elimination. The Committee expects the Secretary to conduct a study and submit information within one year after the enactment of this provision, which would enable the Committee to judge whether the continuation of the mandated referral by a physician is appropriate. Your Committee expects that the Secretary, in conducting the study, will consult with psychiatrists, psychologists, and physicians in the general practice of medicine with respect to whether the requirement is necessary to assure that the beneficiary receives all appropriate medical and mental health service. The Secretary, in his examination of this issue, should also weigh the implication of eliminating the referral requirement on general medicare program policy.

PAYMENTS TO RADIOLOGISTS AND PATHOLOGISTS (SECTION 22)

Under the Committee bill, the special 100 percent reimbursement (with no deductible) for services to hospital inpatients by physicians in the fields of radiology and pathology would be limited to physicians who agree to accept assignment for all services furnished to hospital inpatients.

Currently, radiologists and pathologists are reimbursed 100 percent of the reasonable charge for services furnished to inpatients of a hospital. This occurs whether or not the physician accepts assignment. (In accepting assignment, a physician agrees to accept the medicare reasonable charge as payment in full.) Reimbursement for all other covered physicians' services is subject to a 20 percent coinsurance and a yearly $60 deductible.

The provision entitling radiologists and pathologists to 100 percent of the reasonable charge was adopted in the 1967 Social Security Amendments to permit a simplified hospital and physician combined billing arrangement. At the time it was felt that the amendment was needed because of the practice of some hospitals of submitting combined billings for both the physician's services and the hospital's laboratory and radiology services. The latter are reimbursable under part A and the former under part B. Because deductible and coinsurance amounts for the two parts differed, it was difficult not only to allocate the combined charge between parts A and B in individual bills, but also to subject those allocated charges to separate deductibles. It was anticipated that administrative savings would accrue as a consequence of the combined billing arrangement.

Contrary to that anticipation, many of these physicians bill the patient directly, rather than combining their billings with those of the

hospital. As a consequence, the physicians receive the benefit of 100 percent reimbursement without the expected benefit to the beneficiary or the medicare program. (If the physician services are billed for by the hospital, the beneficiary is assured that he will not have to pay any additional amounts. A physician billing the beneficiary directly can charge and demand payment of more than the medicare reasonable charge.)

This provision would require radiologists and pathologists to accept assignment as the quid pro quo for the waiver of the deductible and coinsurance. Physicians refusing to accept assignment for services provided to medicare inpatients would bill on an unassigned basis, with the medicare program reimbursing the beneficiary for the reasonable charge, less applicable cost-sharing.

SHORTENED PART B TERMINATION PERIOD WHERE MEDICAID HAS CEASED TO PAY PREMIUMS (SECTION 23)

The Committee bill would permit an individual whose State buy-in coverage for part B of medicare has ended to terminate part B coverage effective with the month in which he notifies the Health Care Financing Administration (HCFA) that he does not want part B coverage.

Under present law when State buy-in coverage is terminated, an individual's enrollment in part B is continued automatically unless he requests that his coverage be terminated. After such a request an individual's coverage may not be terminated until the close of the calendar quarter in which the request is made. This results in the individual's coverage and premium liability continuing for anywhere from 3 to 6 months after the State has ceased its buy-in coverage.

This provision would require States to notify the beneficiary and HCFA of their final decision on or before the effective date the individual's buy-in coverage was terminated (assuming that the State had previously given the individual prior notification of its intent to terminate and an opportunity for a hearing under the due process provisions). Following the State's notification, HCFA would also be required to notify the beneficiary that State termination of buy-in had occurred.

OUTPATIENT PHYSICAL THERAPY SERVICES (24)

The bill would increase the present $100 limitation on outpatient services furnished by independently practicing physical therapists to $500.

The $100 limitation in present law, initially imposed in the Social Security Amendments of 1972, was intended to help control program expenditures and to reduce the potential for over-utilization of these newly covered services. However, the increases in medical costs since 1972 have resulted in a reduction in the value of the original $100 limit to the extent that this amount now purchases considerably less services. This decline in purchasing power creates serious problems for those beneficiaries who require the services of independently practicing therapists.

In deciding to increase the dollar limitation on reimbursement for physical therapy services provided by private practitioners, the Com-

mittee recognizes that as an alternative, a limit could be imposed on the number of patient visits. A visit limit similar in concept to that which has in the past been imposed on home health agenices has the possible benefit of avoiding the need for frequent amendments because of inflation. To assist the Committee in weighing the visit limit alternative in the future, the Committee has requested the Secretary to collect and submit data on the costs of physical therapy services provided by therapists in independent practice. The Committee also expects that, in submitting such data, the Secretary would include national comparisons of costs for physical therapy services furnished by independent practitioners and the cost of such services when provided in all other settings covered under the medicare program.

Your Committee is also concerned about several administrative decisions related to coverage of and reimbursement for physical therapy services. In implementing the provisions of the 1972 Social Security Amendments which covered the services of independently practicing physical therapists, statutory and report language has been interpreted by HEW to mean that any physical therapist billing as an independent therapist should maintain an office and necessary equipment at his own expense. The Committee agrees that, in most instances, such a requirement is necessary to assure that the therapist has an established private practice, maintains proper patient records, and has available properly maintained equipment. There are circumstances, however, where the Committee believes that exceptions to the office requirement are appropriate. A number of physical therapists who are primarily engaged in teaching physical therapy in a university occasionally treat a patient in his home. Since the therapist maintains only an office in the teaching institution and does not maintain a separate office at his own expense, services furnished by such a practitioner have not been treated as reimbursable under medicare.

The Committee expects that in this and other circumstances the Secretary determines to be appropriate, where it is evident that the physical therapist is engaged in the practice of physical therapy on a regular basis and where any other appropriate requirements are met (e.g., access to appropriate equipment), such a therapist would be recognized as an independent practitioner for the purpose of medicare reimbursement. It is not expected, however, that a therapist with an office in a teaching institution would provide services in that setting as an independent practitioner; it is expected that services furnished in the institution would be covered, as at present, as part of the institution's services. The Committee further believes that where two or more physical therapists practice in the same setting as independent practitioners, it is not necessary, as is presently required, for the owner of the office or clinic to be present in order for services furnished by other, fully qualified, physical therapists to be covered.

The Committee also intends that, in determining the "adjusted hourly salary equivalency amount" to be used in determining the reasonable cost of all types of therapy services (including physical and respiratory therapy) furnished under arrangements, the Secretary should use the most current data available. If survey data is not available on a current basis, the Committee expects that the data available would be appropriately updated. It is also expected that where appropriate data is available on the actual salary differential between physi-

cal therapy supervisors and non-supervisory physical therapists, that such data would be used to establish the appropriate salary differential rather than data related to salary levels of other professional health care practitioners.

MEDICARE REIMBURSEMENT FOR BLOOD (SECTION 25)

Under the bill, the present medicare deductible, which leaves beneficiaries with the responsibility for replacing or paying for the first three pints of transfused blood, would be eliminated.

Under present law, medicare beneficiaries are responsible for either replacing or paying for (nonreplacement fee) the first three pints of blood furnished during any benefit period (for part A coverage) or calendar year (for part B coverage). The deductible and recognition of the blood nonreplacement fee were originally included in the law both in the interest of voluntary blood replacement programs and to preserve medicare's neutrality with respect to the competing philosophies concerning the mechanism for assuring a steady supply of blood (an all-voluntary system versus one that also includes the use of the economic incentive of a nonreplacement fee.)

Medicare experience demonstrates, however, that a majority of elderly beneficiaries are unable to donate blood themselves or otherwise replace transfused blood and, consequently, must pay the nonreplacement fee. Such fees average $25 per pint and can cost the beneficiary as much as $60 per pint at certain blood banks and hospitals. Thus, the committee's bill would relieve beneficiaries, at a time when they can least afford additional out-of-pocket payments, of this financial burden.

In eliminating the medicare blood deductible, the committee is not intending to set national policy with respect to the issue of the merits of the nonreplacement fee system as a blood recruitment mechanism. Your committee believes it would be inappropriate to attempt to resolve the philosophical dispute within the blood banking community over the comparative merits of the voluntary and nonreplacement fee systems through the back door approach of banning nonreplacement fees in medicare. For that reason, the committee has not precluded medicare reimbursement for nonreplacement fees where a provider may have to pay such a fee in order to replace blood used and not replaced by a beneficiary and has chosen instead to defer to the congressional committees of jurisdiction for resolution of this important question of national blood policy.

MEDICARE PAYMENT LIABILITY SECONDARY WHERE PAYMENT CAN BE MADE UNDER AN AUTOMOBILE INSURANCE POLICY (SECTION 26)

Under your Committee's bill, medicare would have residual rather than primary liability for the payment of services required by a beneficiary as a result of an injury or illness sustained in an auto accident where payment for the provision of such services can also be made under an automobile insurance policy. Under this provision, it is expected that medicare would ordinarily pay for the beneficiary's care in the usual manner and then seek to be reimbursed by the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined.

Under present law, medicare is the primary payor (except where a workmen's compensation program is determined to be responsible for payment for needed medical services) for hospital and medical services received by beneficiaries. This is true even in cases in which a beneficiary's need for services is related to an injury or illness sustained in an auto accident and the services could have been paid for by a private insurance carrier under the terms of an automobile insurance policy. As a result, medicare has served to relieve private insurers of obligations to pay the costs of medical care in cases where there would otherwise be liability under the private insurance contract. Your Committee believes that the original concerns that prompted inclusion of this program policy in the law—the administrative difficulties involved in ascertaining private insurance liability and the attendant delays in payment—no longer justify retaining the policy, particularly if it is understood that immediate payment may be made by medicare with recovery attempts undertaken only subsequently when liability is established.

In order to avoid excessive administrative costs and efforts in pursuing minor recoveries, the Committee expects the Secretary to establish in regulations rules regarding the minimum amounts estimated as recoverable and the procedures for seeking recovery from private carriers. Such procedures would be similar to those currently employed by medicare in seeking recovery in workmen's compensation cases.

HOSPITAL TRANSFER REQUIREMENT FOR SKILLED NURSING FACILITY COVERAGE (SECTION 27)

Under the Committee bill, the 14-day period within which a medicare beneficiary must be transferred from a hospital to a skilled nursing facility in order to qualify for post-hospital extended care benefits (in a skilled nursing facility) would be extended to 30 days. The 14-day limit on readmission to the skilled nursing care facility would also be extended to 30 days.

Under present law, medicare coverage of post-hospital care in a skilled nursing facility is ordinarily available only where the beneficiary has been an inpatient of a hospital for at least three consecutive days and has been transferred to the skilled nursing facility within 14 days after discharge from a hospital. As many as 14 additional days (for a total of 28 days) are permitted where admission to the skilled nursing facility must be deferred because there is no bed available in the skilled nursing facilities ordinarily utilized in the geographic area in which the beneficiary resides. Some administrative complexity is involved in the determination of whether a bed is, in fact, available in the geographic area. Permitting 30 rather than 14 days for transfer to the skilled nursing facility would not only eliminate this administrative complexity, but would also provide a modest liberalization of the hospital transfer requirement.

In addition, present law provides that a beneficiary who leaves a skilled nursing facility can be readmitted to the same or any other participating skilled nursing facility within 14 days without again meeting the 3-day hospitalization requirement. The bill would also increase that 14-day period to 30 days.

OUTPATIENT SURGERY (SECTION 28)

The bill would provide medicare reimbursement for the cost of ambulatory surgical centers when used to perform certain surgical procedures. In addition, the physician's reasonable charge for performing those same procedures on an outpatient basis would be reimbursed at 100 percent provided the physician performing the surgery agreed to accept assignment.

Under present law, medicare reimburses 80 percent of a physician's fee for surgery, regardless of the setting in which the surgery is performed—in a hospital, the outpatient department of a hospital, or an ambulatory surgical center. Medicare will also reimburse 100 percent of the facility's cost if the surgery is performed in a hospital and 80 percent of the facility's cost if the surgery is performed in a hospital outpatient department or in a free-standing ambulatory surgical center that is owned by the hospital. However, medicare law prohibits reimbursement for any costs incurred by a surgical facility if the facility is not hospital-affiliated.

There are a number of surgical procedures which are ordinarily performed on an inpatient basis but which can, consistent with sound medical practice, be performed on an outpatient basis for far less cost. Medicare, however, discourages the appropriate use of ambulatory surgery since the facility cost is fully reimbursed only on an inpatient basis and, in the case of all free-standing centers, is not reimbursed at all.

This provision would provide 100 percent reimbursement for services furnished by ambulatory surgical facilities for the performance of procedures which, although appropriately performed on a hospital inpatient basis, are determined by the Secretary to be also safely performed in an ambulatory surgical center. It is not your Committee's intent that this list include surgical procedures which would be performed on an outpatient basis in the absence of the elaborate surgical facilities in an ambulatory surgical center. For example, it would not be appropriate to cover the types of surgical procedures routinely performed in a physician's office in the more costly setting of an ambulatory center. The Committee expects that the ambulatory center will serve as a setting to be used in lieu of hospital inpatient facilities. The reimbursement authorized under this provision would be paid only where the ambulatory surgical center agreed to accept the medicare payment as payment in full. The ambulatory surgical center would be required to meet certain health and safety standards.

The physician performing such procedures in a free-standing ambulatory surgical center or in the outpatient department of a hospital would be reimbursed 100 percent of the medicare reasonable charge for the services (including all pre- and post-operative services) furnished in connection with the procedure, provided the physician agrees to accept assignment.

In developing the list of procedures eligible for such reimbursement, the Secretary would be required to consult with the National Professional Standards Review Council and appropriate medical organizations, including specialty groups.

TECHNICAL AMENDMENT TO END-STAGE RENAL DISEASE PROGRAM (SECTION 29)

The bill amends the end-stage renal disease program to correct a defect in present law which has inadvertently resulted in certain reimbursement problems for nonprofit organizations assisting home dialysis patients. In addition, the bill changes the reporting date for the Secretary's annual reports to the Congress on the medicare renal disease program from April 1, to July 1.

Under present law, the Secretary may enter into agreements with providers and facilities to reimburse them for the full reasonable cost of the purchase and maintenance of dialysis equipment used by individuals who dialyze at home. However, certain nonprofit organizations which were engaged in assisting home dialysis patients to obtain and maintain such equipment at the time this provision was enacted in 1977, have been denied reimbursement under this provision.

Under the bill, therefore, the Secretary may enter into agreements with organizations such as State kidney programs and nonprofit institutions to provide machines to beneficaries through direct purchase. The Committee expects that the Secretary will enter into such agreements with entities that demonstrate to his satisfaction that they can provide dialysis machines and supportive equipment economically and efficiently. Like providers and facilities, these entities would be reimbursed on the basis of their reasonable costs and would be required to provide the Secretary full access to cost and other data and submit reports as required by the Secretary with respect to cost, management and use of equipment. Should the Secretary find that such an entity fails to provide equipment efficiently and economically, the Committee expects that the Secretary would terminate the agreement.

The Committee's bill changes the reporting date for the annual renal disease program reports to allow the Secretary more time to gather and analyze the data required in such reports.

PREADMISSION DIAGNOSTIC TESTING (SECTION 30)

Under your Committee's bill, diagnostic tests performed on an outpatient basis within 7 days of a patient's admission to the hospital would be reimbursed in full (with no deductibles or coinsurance).

In some cases, the diagnostic tests necessary prior to treatment as an inpatient can be performed on an outpatient rather than inpatient basis. Where this is possible, the patient's length of stay in the hospital can be reduced with substantial savings in hospital expenditures. However, whereas the diagnostic testing provided on an inpatient basis is reimbursed at 100 percent, the same service provided on an outpatient basis is reimbursed at the 80 percent rate. Thus, the patient has an economic incentive to be admitted as an inpatient for the testing.

The bill would eliminate any such incentive by providing for reimbursement at the 100 percent rate for outpatient diagnostic tests provided within seven days of admission to the same hospital where the outpatient tests are furnished. (Not only the hospital costs, but also the reasonable charges of physicians in the fields of radiology and pathology if the physicians accept assignment of the medicare claim would be reimbursed at the 100 percent rate, just as they would be on an

inpatient basis.) Because of the administrative difficulty of coordinating claims for tests furnished in a hospital other than the one where the beneficiary is subsequently admitted as an inpatient, the Secretary would be directed to provide for payment-in-full for diagnostic services provided in these settings only to the extent feasible. The Secretary, however, would be required to report to the Congress a year after enactment as to the progress in developing the policy necessary to implement this additional coverage.

STUDIES AND DEMONSTRATION PROJECTS (SECTION 31)

The bill would require the Secretary to study or conduct demonstrations and report to Congress with respect to the following issues:

Coverage for Orthopedic Shoes.—Under present law, orthopedic shoes and other supportive devices for the feet are generally excluded from medicare coverage. The only situation in which the exclusion does not apply is if the orthopedic shoe is provided as an integral part of a leg brace. However, it would be costly to provide coverage for orthopedic shoes, even if the coverage were limited to cases where a physician certifies that the shoes are medically necessary. This provision would direct the Secretary to study and submit legislative recommendations to the Congress no later than January 1, 1981, with respect to the coverage of orthopedic shoes where such shoes are required as an appropriate part of medical treatment.

Expanded Coverage for Services of Clinical Social Workers.—Services furnished by clinical social workers are presently covered when furnished to inpatients of hospitals and skilled nursing facilities, as home health services for those who are otherwise eligible for home health benefits, and when furnished incident to a physician's service. Under the Committee's bill, clinical social workers' services would also be covered when furnished in a community mental health center. This provision would direct the Secretary to conduct a demonstration project and submit recommendations, no later than 24 months after enactment, for any legislative changes with respect to additional coverage for services of clinical social workers.

Nutritional Therapy for Renal Disease Patients.—The Secretary would be authorized the make further studies, conduct a demonstration project and submit legislative recommendations to the Congress, no later than 24 months after enactment, as to whether the use of nutritional therapy in early renal failure, utilizing (but not limited to controlled protein substances, can retard or arrest the progression of the disease with a resultant deferment of dialysis. Some recent studies reported in the professional literature have indicated that chronic renal failure may be retarded or even arrested by controlling dietary protein intake. Your Committee believes that the potential impact of such nutritional therapy on the treatment of chronic renal failure could be significant. Moreover, the cost of the present dialysis-oriented medicare renal disease program could be somewhat reduced if such a therapeutic approach were found to be viable in a substantial number of cases. The Committee expects that in establishing the demonstration project the Secretary will consult physicians with nutritional expertise who have had experience in treating patients with chronic renal disease.

Expanded Coverage for Respiratory Therapy Services.—Under present law, services furnished by respiratory therapists are covered when furnished as an inpatient service in a hospital or skilled nursing facility or as a service furnished by the outpatient department of a hospital. The Committee believes it possible that such services might also be appropriately furnished as a home health service to individuals who are otherwise eligible for home health benefits. Under the provision, the Secretary would be directed to study the need for coverage of respiratory therapy services as a home health benefit and recommend, no later than 24 months after enactment, under what circumstances and conditions respiratory therapy services should be covered, for example, by type of medical diagnosis.

100 Percent Reimbursement for Second Opinions for Surgery.—The Committee believes that sufficient evidence exists that obtaining a second opinion can in many cases avoid unnecessary surgery to warrant consideration of providing 100 percent reimbursement for the second opinion. The 100 percent payment, in lieu of the usual 80 percent coverage of the physician's fee, would, it is hoped, encourage more beneficiaries to seek second opinions. There is some concern, however, as to what effect such a higher rate of payment would have on overall program costs. There might also be administrative problems in determining when the 100 percent reimbursement is appropriate. Under the Committee's bill, the Secretary would, therefore, be required to evaluate demonstration projects currently being conducted by HEW on 100 percent reimbursement for surgical second opinions and report to the Congress, no later than 12 months after enactment, on the effect on surgical rates, the effect on program expenditures and any problems involved in administering such a program.

Home Health Services of Registered Dietitians.—In recent years nutritional counseling and management by registered dietitians, particularly for the aged, has been recognized as an important component of patient care. While medicare does recognize for reimbursement purposes the salary of a dietitian employed by a home health agency to provide general guidance on nutritional matters, no coverage is provided with respect to visits that might be made by the dietitian to the patient's home. To help evaluate alternative possibilities for changing current law, the Secretary would be directed to study (and, if necessary, conduct a demonstration project) on questions related to the coverage of dietitian visits, e.g., whether the number of covered visits should be related to diagnosis, and what criteria might be appropriately employed to assure proper utilization. The Secretary is to submit to the Congress a report on the study and any demonstration projects along with any legislative recommendations no later than 24 months after enactment.

Study of Costs of Various Types of Foot Care.—Under present law there are a number of foot conditions currently excluded as routine foot care that are both pathological and, in many cases, severely disabling rather than merely irritants or inconveniences. The Secretary is directed, therefore, to make a comprehensive analysis of the cost of expanded coverage of foot care, including the cost effects of alternative approaches to improving medicare coverage for specific types of foot conditions. The Secretary is to submit the analysis to the Congress within 24 months after enactment.

PROVIDER REIMBURSEMENT REVIEW BOARD (SECTION 32)

The bill authorizes the Provider Reimbursement Review Board to determine, on its own motion or at the request of a provider of services, whether it has jurisdiction over an issue brought before it by the provider. On the basis of a determination by the Board that it is without authority to decide the question (or if the Board fails to render such a determination within 30 days of the provider's request) the provider would be permitted to commence a civil action with respect to the matters in controversy without further administrative review.

Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Your committee's bill addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought.

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS (SECTION 32)

The bill provides that medicare will not reimburse amounts paid by providers under contracts for services between the provider and any of its subsontractors, whose value or cost over a twelve month period is $10,000 or more and which are entered into after enactment of the bill, unless such contracts contain a provision allowing the Secretary and the Comptroller General to have access (for the purpose of audit and transcription) to the books, papers and records of the subcontractor that are pertinent to the specific contract. Books, papers and records covered by this provision of the bill must be preserved for three years after the furnishing of services pursuant to the contract.

Under present law, the Secretary does not have access to the books and records of medicare subcontractors unless the subcontractor is shown to be related to the provider. Unlike contracts for goods, contracts for services can pose difficult valuation problems. Consequently, without access to subcontractors' books, the detection and prevention of fraud and abuse can be difficult.

Your committee believes that this provision of the bill is necessary both to strengthen the Secretary's capacity to effectively preclude or detect fraud and abuse and to conform medicare practice to the prevailing practice of other Federal agencies which buy services in the private sector. Moreover, the provision is moderate in scope since it includes only contracts that have a substantial service component (the intent of the value or cost standard is to permit the Secretary to assess the actual terms of the contract) and applies only to contracts entered into after enactment of the bill.

Ambulance Services

Section 1861(s)(7) of the Social Security Act relating to ambulance services states only that such services are covered "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in the regulations." Your committee's report on the legislation that established the medicare program in 1965 stated that the intent was to provide a limited ambulance benefit, and the report was specific that the only transportation to be covered is to a hospital or skilled nursing facility and back to a patient's home. In addition, the transportation to a hospital was restricted by the report language to transportation to the nearest hospital with "appropriate facilities."

Such language has been interpreted to mean that the availability of a physcian is not a consideration in determining whether a hospital has appropriate facilities. Occasionally, the nearest hospital, while adequately equipped, does not have a physician to provide the necessary service—for example, no neurosurgeon when neurosurgery is required. In such cases, medicare payment for the ambulance transportation has been limited to the amount that would have been paid had the patient been transportation to the nearest hospital with appropriate facilities, even though the patient must in fact be transported to another, more distant, facility to obtain the necessary services.

It is your committee's intention that the statutory language in 1861(s)(7) be interpreted so as to also include ambulance service to a more distant hospital where the nearer hospital does not have appropriate medical staff. This will greatly benefit beneficiaries who must now be transported to the more distant facility at their own expense.

The committee has found other instances in which hospital or skilled nursing facility patients or patients confined to their homes require ambulance transportation to and from radiological services which are in a nonhospital-affiliated outpatient setting—that is, a freestanding radiological center or a physician's office. For example, a hospital may use the radiological equipment in a nearby freestanding radiological center rather than purchase its own. But since the setting is not part of a hospital, the ambulance transportation to the freestanding center is not covered.

Your committee believes that ambulance services furnished in a freestanding radiological setting should be covered so as to eliminate the illogical situation where the program must pay to have the patient transported to a more distant radiological service which is part of a hospital when a more convenient facility is available. This change is also intended to eliminate the situation where the beneficiary is transported to a freestanding setting but must pay for the ambulance service out of his own pocket. Such a benefit expansion will be safeguarded against possible overutilization by covering such ambulance transportation to a free standing facility only where: (i) Other methods of transportation are not medically appropriate: (ii) the service is not available in the hospital where the beneficiary is an inpatient—if he is an inpatient—or in a hospital in the locality; (iii)

the service for which the beneficiary is being transported is a covered service; and (iv) where a State provides for such approval, the radiological service is approved by the State health planning and development agency.

RESIDENCE IN AN INSTITUTION AND ITS EFFECT ON COVERAGE OF DURABLE MEDICAL EQUIPMENT AND SPELL OF ILLNESS

Your committee believes that there is a critical need for a more discriminating interpretation of existing law in order to avoid inappropriately denying coverage for durable medical equipment to beneficiaries living in residential institutions. Where a legitimate question exists as to the primary purpose of an institution it is essential to apply more selective criteria than nurse-patient ratios in order to realistically distinguish between skilled nursing and residential facilities. Your committee is concerned about the fact that the failure to apply such criteria, even though such an approach was intended under present law, has resulted in some cases in the inappropriate denial of coverage for durable medical equipment obtained by beneficiaries living in residential facilities. It is expected, therefore, that the Secretary will promptly develop and utilize appropriate additional criteria in making such determinations. It is not intended, however, that current policies relating to reimbursement to durable medical equipment suppliers be changed. On the contrary, it is expected that the Secretary will continue to apply in medicare the policies that residential facilities cannot be reimbursed as suppliers of durable medical equipment, and that payment to suppliers will be made only for such equipment as is not ordinarily maintained or provided for the use of its occupants by such facilities.

Your committee is also concerned about the predicament of beneficiaries who exhaust their benefits because they are unable to start a new spell of illness as long as they are residing in an institution that provides some skilled nursing care.

The committee expects the Secretary to make a comprehensive reassessment of possible solution to this problem. This study should also take into account the relationship between medicare criteria for qualification as a skilled nursing facility and state licensure personnel requirements for various types of nursing and domiciliary facilities. Your committee expects the Secretary to submit the results of this study and any legislative recommendations he determines are appropriate to the Congress.

CLARIFICATION OF SECRETARY'S EXPERIMENTAL AUTHORITY

In a continuing effort to assure the most efficient, economical and effective administration of the medicare program, the Congress has authorized the Secretary to conduct experiments and demonstration projects in order to assess the feasibility and desirability of adopting alternative approaches to the present system of contracting for the administration of the program. In the Social Security Amendments of 1972, for example, the Secretary was directed to experiment with

the concept of providing for the performance of claims processing and related functions on the basis of a prospective fixed-price. The intent of that legislation was to provide (in this area, as well as a number of other areas of prescribed program experimentation) for the testing, on a limited and controlled basis, of administrative and contracting techniques. The expectation of your committee was that such experimentation would permit the accumulation of sufficient data and experience to enable the committee and the Congress to evaluate the potential implications of these administrative techniques before taking any legislative steps to convert or significantly modify the extensive and complex apparatus through which the medicare program is presently administered. It was in this context that the committee authorized the Secretary to waive compliance with the requirements of title XVIII, including those provisions that, if applied, might impede the effective and productive implementation of the prescribed experimental projects. The committee has, in fact, deliberately refrained from changing the contracting process of present law—even though your committee's Subcommittee on Health considered proposals to amend this bill in just such a manner—because of its conclusion that such action should await the results of experimentation with these alternative approaches.

Your committee would emphasize, however, that the experimental authority granted to the Secretary under present law was intended for use exclusively in a limited number of experimental settings and not for use as a possible means for circumventing the requirements of present law in non-experimental settings. While the committee is not aware of any attempts by the Secretary to so circumvent the rights of nominated intermediaries or their nominating providers, the committee believes it will be helpful to allay such possible concerns by reaffirming the committee's intent on this point. Moreover, the committee expects that the Secretary will exercise the greatest care in both the selection of experimental sites and the design and timing of the experimental projects so as to assure ample notice to all affected parties (including beneficiaries), reasonable opportunity for incumbent intermediaries to comment on the proposed experiment, and a competitive procurement design (if that is involved in the experiment) that does not automatically eliminate the possibility of the incumbent intermediary submitting a potentially successful bid for the contract. But, given the application of these reasonable precautions, the intent of present law is to allow sufficient flexibility for the Secretary to implement the various kinds of administrative experiments contemplated by the Congress and to authorize the waiver of such provisions as provider nominations of intermediaries where in the Secretary's judgment such waiver is necessary to satisfy the conditions of the experiment.

Medicare Reimbursement for Provider Litigation Expenses

Your committee is concerned about the present medicare practice of reimbursing providers, without any apparent limitations or restrictions, for their litigation expenses (including attorneys' fees) incurred in pursuing actions against the government. The committee believes that this practice has served to create incentives for excessive

litigation, or, at least, failed to deter a considerable body of litigation lacking in merit, and has resulted in excessive medicare payments for attorneys' fees and other litigation expenses. Your committee was unable to arrive at a completely satisfactory solution to the problem, partly because of the paucity of cost data on the volume and types of medicare expenditures in this area, and partly because there are a number of difficult policy questions relating to such matters as the potential chilling effect on legitimate litigation of limitations on attorneys' fees, the role of the courts in determining the merit of provider actions, and the contractual relationships between attorneys and providers of services. Nevertheless, the committee did agree that certain steps appear to be warranted and need to be taken now by the Secretary both to evaluate the appropriateness and cost effects of present medicare policy and to implement new guidelines and procedures with respect to program reimbursement for litigation expenses.

First, since the committee believes there are good grounds for assuming that medicare reimbursement for provider attorney fees is excessive, the committee expects the Secretary to: (1) undertake an immediate reassessment of the current medicare reimbursement guidelines; (2) compile the relevant data on medicare reimbursement for litigation expenses; (3) examine the practices and policies of other Federal agencies with respect to this issue; and (4) submit the findings of this study to the committee with any legislative recommendations that appear to be warranted.

Secondly, since the committee believes that the Secretary has authority under present law to institute appropriate changes in medicare reimbursement policies, the committee directs the Secretary to take the following actions: Utilizing the prudent buyer principle, as well as the general authority in present law to limit medicare reimbursement to reasonable costs, the Secretary is to establish guidelines for applying reasonable limitations on litigation expenses (including attorneys' fees) incurred by providers in pursuing civil actions, particularly litigation in which there is clearly inadequate justification for the action or little prospect of success in the appeal of a determination. Such guidelines should define the circumstances in which the criteria for imposing limitations are to be applied (for example, the committee does not intend to deter the use of administrative remedies); and the range of limitations that will be applied (so as to assure that providers will know in advance of the potential consequences of alternative courses of action). The committee also expects that the Secretary will take into consideration, and in appropriate cases, solicit the judgments of the courts with respect to the merits of actions. It is your committee's judgment that such guidelines can be appropriately developed and applied now.

IV. Cost of Carrying Out the Bill and Effect on the Revenues

The following information relative to the costs of carrying out the bill was furnished your committee by the Health Care Financing Administration's Office of Financial and Actuarial Findings (Department of Health, Education and Welfare):

COST ESTIMATE

[By fiscal years; in millions of dollars]

	Section	1980	1981	1982	1983	1984
	OUTLAYS					
2	Home health services	12	44	53	61	69
3	Elimination of the 2d waiting period for reentitled disability beneficiaries	27	45	54	60	66
4	Reciprocal agreements for coverage outside the United States			(1)	(1)	(1)
5	Dentists' services	14	15	16	18	20
6	Treatment for plantar warts	2	2	2	2	2
7	Community mental health centers	7	55	75	90	110
8	Comprehensive outpatient rehabilitation centers	5	11	13	15	17
9	Optometrists' services	1	1	2	2	2
10	Antigens	(2)	(2)	(2)	(2)	(2)
11	Payment where beneficiary is not at fault	(2)	(2)	(2)	(2)	(2)
12	Flexibility in application of standards for rural hospitals	0	0	0	0	0
13	Certification and utilization review by podiatrists	0	0	0	0	0
14	Physician treatment plan for speech pathology	0	0	0	0	0
15	Payment for physicians' services where beneficiary has died	0	0	0	0	0
16	Presumed coverage provisions	0	0	0	0	0
17	Payment to providers of services	−2	−7	−8	−10	−12
18	Limit on premium increases due to late enrollment	1	8	9	10	11
19	Reenrollment in part B	(2)	(2)	(2)	(2)	(2)
20	Chiropractors' services	29	44	49	55	61
21	Outpatient mental health benefits	26	46	61	77	94
22	Payments to radiologists and pathologists	−5	−15	−17	−20	−24
23	Shortened part B termination period where medicaid has ceased to pay	0	0	0	0	0
24	Outpatient physical therapy services	2	4	5	5	5
25	Medicare reimbursement for blood	20	25	30	35	45
26	Medicare payment liability secondary in certain automobile insurance cases	0	0	−30	−35	−40
27	Hospital transfer requirement for skilled nursing facility coverage	(2)	(2)	(2)	(2)	(2)
28	Outpatient surgery	−1	−2	−4	−6	−9
29	Technical renal disease amendment	(2)	(2)	(2)	(2)	(2)
30	Preadmission diagnostic testing	−2	−5	−10	−15	−20
31	Studies and demonstration projects	(2)	(2)	(2)	(2)	(2)
32	Provider reimbursement review board	0	0	0	0	0
	Ambulance service	(2)	1	1	1	2
	Durable medical equipment	(2)	(2)	(2)	(2)	(2)
	Total outlays	146	272	301	345	399
	BUDGET AUTHORITY[3]					
20	Part B—Late enrollment	(2)	7	7	9	9

[1] Indeterminate.
[2] Negligible cost or savings.
[3] Includes both premium income and general revenue transfer.

The estimated costs of carrying out the bill provided to your committee by the Director of the Congressional Budget Office follow:

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., November 5, 1979.

Hon. AL ULLMAN,
Chairman, Committee on Ways and Means,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3990, the Medicare Amendments of 1979.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

ALICE M. RIVLIN,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 3990.
2. Bill title: Medicare Amendments of 1979.
4. Bill status: As ordered reported by the Committee on Ways and Means on October 30, 1979.
4. Bill purpose: The bill amends title XVIII of the Social Security Act with respect to the medicare program. The bill provides for a variety of benefit improvements. Several provisions would reduce out-of-pocket expenses of beneficiaries by either increasing the total amount payable within a year for particular services or by reducing copayments. Other provisions would expand benefits by making certain classes of providers or certain services of some providers eligible for reimbursement. The bill contains several provisions that alter the conditions or requirements relating to enrollment or reenrollment in the medicare programs. Finally, the bill includes several provisions that would reduce program outlays either by encouraging more efficient provision of medical care services or by making changes in payment procedures and requirements.
5. Cost estimate:

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
A. Direct Spending Provisions					
Medicare:					
Estimated budget authority	0	7.0	7.0	9.0	9.0
Estimated outlays:					
Sec. 2 Home health services	10.9	41.8	62.0	95.4	148.1
Sec. 3 Elimination of second waiting period for re-entitled disability beneficiaries	16.8	61.4	103.2	116.1	128.8
Sec. 5 Dentists' services	10.5	16.4	19.1	21.9	25.2
Sec. 6 Treatment for plantar warts	1.5	2.3	2.7	3.1	3.6
Sec. 7 Community mental health centers	7.0	55.0	75.0	90.0	110.0
Sec. 8 Comprehensive outpatient rehabilitation centers	1.5	11.0	12.8	14.7	16.9
Sec. 9 Optometrists' services	1.0	1.2	1.4	1.6	1.8
Sec. 10 Antigens	.1	.2	.2	.3	.3
Sec. 17 Payments to providers of services	−2.0	−7.0	−8.0	−10.0	−12.0
Sec. 18 Limit on premium increase due to late enrollment	1.0	8.0	9.0	10.0	11.0
Sec. 20 Chiropractors' services	29.0	46.0	53.0	61.0	70.0
Sec. 21 Outpatient mental health services	26.0	46.0	61.0	77.0	94.0
Sec. 22 Payments to radiologists and pathologists	−5.0	−15.0	−17.0	−20.0	−24.0
Sec. 24 Outpatient physical therapy services	2.0	5.0	6.0	6.0	7.0
Sec. 25 Mecidare reimbursement for blood	20.0	45.0	52.0	60.0	69.0
Sec. 26 Medicare payment liability secondary in certain automobile insurance cases	−32.7	−50.2	−72.5	−83.6	−96.2
Sec. 28 Outpatient surgery	−4.5	−8.1	−18.0	−45.9	−81.0
Sec. 30 Preadmission diagnostic testing	−2.3	−5.4	−9.6	−15.1	−22.3
Total, medicare outlays	80.8	253.6	332.3	382.5	450.2
Costs	127.3	339.3	457.4	557.1	685.7
Savings	−46.5	−85.7	−125.1	−174.6	−235.5
B. Amounts Subject to Appropriation Action					
Medicaid: Sec. 23 Home health services:					
Required budget authority	−1.0	−2.2	−2.5	−2.7	−3.0
Estimated outlays	−1.0	−2.2	−2.5	−2.7	−3.0
Total outlays	79.8	251.4	329.8	379.8	447.2

The costs of this bill fall within budget function 550.

Portions of the bill would reduce future federal liabilities through a change to an existing entitlement and therefore could permit subsequent appropriations action to reduce the budget authority for the medicaid program. The figures shown as "Required Budget Authority" represent that amount by which budget authority for the medicaid

program could be reduced, as a result of this bill, below the level needed under current law.

6. Basis of estimate: This cost estimate assumes enactment by November 30, 1979. Lack of time precludes a detailed discussion of the basis of estimate for this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: On April 19, 1979, CBO provided the Committee on Ways and Means a cost estimate for H.R. 3236. That bill contained two sections with provisions identical to section 3 of this bill. The estimate for those provisions in H.R. 3236 and for section 3 of this bill are identical, except in the first year for which a later effective date is assumed.

9. Estimate prepared by: Eric Wedum.

10. Estimate approved by:

C. G. Nuckols,
(For James L. Blum, Assistant Director for Budget Analysis).

Your committee concludes that, based on a review of the assumptions made and the methods of derivation used by the Department of Health, Education and Welfare and the Congressional Budget Office, use of the following estimates for the provisions in H.R. 3990 are appropriate:

COST ESTIMATE

[By fiscal years; in millions of dollars]

Section		1980	1981	1982	1983	1984
	OUTLAYS					
2	Home health services	12	44	53	61	69
3	Elimination of the 2d waiting period for reentitled disability beneficiaries	27	45	54	60	66
4	Reciprocal agreements for coverage outside the United States			(1)	(1)	(1)
5	Dentists' services	14	15	16	18	20
6	Treatment for plantar warts	2	2	2	2	2
7	Community mental health centers	7	55	75	90	110
8	Comprehensive outpatient rehabilitation centers	5	11	13	15	17
9	Optometrists' services	1	1	2	2	2
10	Antigens	(2)	(2)	(2)	(2)	(2)
11	Payment where beneficiary is not at fault	(2)	(2)	(2)	(2)	(2)
12	Flexibility in application of standards for rural hospitals	0	0	0	0	0
13	Certification and utilization review by podiatrists	0	0	0	0	0
14	Physician treatment plan for speech pathology	0	0	0	0	0
15	Payment for physicians' services where beneficiary has died	0	0	0	0	0
16	Presumed coverage provisions	0	0	0	0	0
17	Payment to providers of services	−2	−7	−8	−10	−12
18	Limit on premium increases due to late enrollment	1	8	9	10	11
19	Reenrollment in part B	(2)	(2)	(2)	(2)	(2)
20	Chiropractors' services	39	44	49	55	61
21	Outpatient mental health benefits	26	46	61	77	94
22	Payments to radiologists and pathologists	−5	−15	−17	−20	−24
23	Shortened part B termination period where medicaid has ceased to pay	0	0	0	0	0
24	Outpatient physical therapy services	2	4	5	5	5
25	Medicare reimbursement for blood	20	25	30	35	45
26	Medicare payment liability secondary in certain automobile insurance cases	−32.7	−50.2	−72.5	−83.6	−96.2
27	Hospital transfer requirement for skilled nursing facility coverage	(2)	(2)	(2)	(2)	(2)
28	Outpatient surgery	−4.5	−8.1	−18	−45.9	−81.0
29	Technical renal disease amendment	(2)	(2)	(2)	(2)	(2)
30	Preadmission diagnostic testing	−2.3	−5.4	−9.6	−15.1	−22.3
31	Studies and demonstration projects	(2)	(2)	(2)	(2)	(2)
32	Provider reimbursement review board	0	0	0	0	0
	Ambulance service	(2)	1	1	1	2
	Durable medical equipment	(2)	(2)	(2)	(2)	(2)
	Total outlays	109.5	215.3	244.9	256.5	268.5
	BUDGET AUTHORITY[3]					
20	Part B—Late enrollment	(2)	7	7	9	9

[1] Indeterminate.
[2] Negligible cost or savings.
[3] Includes both premium income and general revenue transfer.

V. Other Matters to be Discussed Under the House Rules

VOTE OF THE COMMITTEE

The bill, H.R. 3990, as amended, was ordered favorably reported by a voice vote.

OVERSIGHT FINDINGS

Your Committee, in its ongoing review of the operation of the medicare program, has conducted a number of hearings over the past few years to review the adequacy of the benefit structure as well as the administration of the program. Such hearings were conducted by your Committee's Subcommittee on Health in June of 1978 and again of June 1979. Many areas of the medicare law which need improvement have also been brought to your Committee's attention through correspondence from concerned beneficiaries.

In 1976, your Committee's Subcommittees on Health and Oversight announced a major study of home health services under the medicare program designed to eliminate uncertainty about the nature and extent of abuses and to provide the data necessary to permit your Committee to more effectively evaluate legislative proposals for changes in and expansion of the home health benefit. On September 13, 1976, these two subcommittees conducted a hearing on excessive or unnecessary services, the billing of excessive costs to the medicare program and the existence of certain questionable competitive practices of some home health providers. On March 8 and 9, 1977, the Health and Oversight Subcommittees also held hearings jointly with the Senate Special Committee on Aging to examine issues related to the fiscal integrity of home health programs under the Social Security Act. In August 1978 your Committee's Subcommittee on Oversight continued its investigations of medicare abuses in the home health industry. Although many of the abusive practices that were uncovered during these investigations have been addressed in Public Law 95–142, the medicare-medicaid anti-fraud and abuse bill, these hearings were also helpful to your Committee in addressing in this legislation the issues of standards and reimbursement guidelines to insure the effective administration of the home health benefit.

NEW BUDGETARY AUTHORITY AND TAX EXPENDITURES

The changes made in present law by this bill involve no new or increased tax expenditures. With respect to new budget authority, section 18 of the bill, which places a limit on increases in medicare premium due to late enrollment is estimated to result in a slight increase in the number of beneficiaries who elect to enroll. To the extent that there are such additional enrollees, there will be added premium income to the part B trust fund. This increase in premium income plus general revenue transfers to the trust fund, which would be considered new budget authority for purposes of the budget act, is estimated to be negligible in fiscal year 1980 and to rise to $9 million by fiscal years 1983 and 1984.

OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

No oversight findings or recommendations have been submitted to your Committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

INFLATIONARY IMPACT

The changes made in existing law by this bill would have a negligible inflationary impact on prices and costs in the operation of the national economy.

VI. Section-by-Section Analysis of the Bill

Section 1. The first section contains the short title of the bill "Medicare Amendments of 1979."

Section 2. Home Health Services

Section 2 of the bill amends the appropriate sections of title XVIII and title II of the Social Security Act and the Railroad Retirement Act of 1974 to eliminate the three-day prior hospitalization requirement under part A of Medicare; the present limitation on the number of visits available under parts A and B; and the part B $60 deductible with respect to home health services. These amendments are effective with respect to services furnished on or after July 1, 1980.

Sections 1814(a) and 1835(a) are amended by adding a new sentence at the end thereof to require that the physician who performs the certification for home health services and establishes the plan of treatment could not have a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing the services. Sections 1814(a)(2)(D) and 1835(a)(2)(A) of the Social Security Act are amended to include occupational therapy as one of the skilled services that determines a beneficiary's eligibility for home health benefits. Section 1861(m)(4) of the Social Security Act is amended to provide that the home health aide services covered as a home health service must be furnished by a home health aide who has successfully completed a training program approved by the Secretary.

Section 1861(o) is amended to provide that proprietary home health agencies shall be subject to the same licensing requirements as nonprofit home health agencies and shall no longer be required to meet additional standards and requirements. Section 1861(o) is also amended by adding a new paragraph (7) to provide that a home agency, for the purpose of participation in the Medicare program, is one which meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts for financial security purposes) as the Secretary finds necessary for the effective and efficient operation of the program. Section 1861(e) is amended by adding a new paragraph (4) which directs the Secretary to designate regional agencies or organizations to serve as intermediaries for home health agencies in that region except that a hospital-based home health agency would be assigned to such a designated regional intermediary only if the Secretary determines that this assignment results in the more effective and efficient administration of the Medicare program.

Section 1861(v)(1) is amended by adding a new subparagraph (G), which excludes cost related to bonding or establishing an escrow account and interest on borrowing incurred to repay Medicare overpayments (unless the agency was acting in good faith in borrowing the amounts) from the determination of reasonable cost for home health agencies. New subparagraph (G) also contains provisions relating to reimbursement of costs incurred by a home health agency under a

service contract. For service contracts entered into after the date of enactment of the bill, new subparagraph (G) prohibits reimbursement for amounts paid under home health agency contracts whose terms exceed 5 years or which determine the amount payable on the basis of a percentage of the home health agency's Medicare reimbursement. For existing percentage contracts, new subpargraph (G) limits reimbursement to the reasonable value of the services provided as determined by the Secretary.

The amendments relating to physician certification and training for home health aides are effective with respect to services furnished on or after July 1, 1980. The amendments directing the Secretary to designate regional intermediaries, eliminating the present additional requirements for proprietary home health agencies and providing authority for additional standards for home health agencies are effective immediately, except that the Secretary is directed to take administrative actions to assure that improvements, in accordance with the authority to establish additional standards, will be made with respect to home health services by June 30, 1980.

Section 3. Elimination of Second Waiting Period for Reentitled Disability Beneficiaries

Section 3(a) amends sections 226(b), 1811, and 1837(g)(1) of the Social Security Act, and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 by striking out the word "consecutive" wherever it appears, thereby modifying the medicare 24-month waiting period requirement so that these months need not be consecutive.

Section 3(b) further amends section 226 by adding a new subsection, which provides that, for an individual who is reentitled to the same type of monthly disability benefits, the 24-month waiting period may not include any month in a previous period of disability, if (1) the individual is reentitled as a disabled worker and the previous period of disability terminated more than 60 months before reentitlement; or (2) the individual is reentitled as an adult disabled since childhood, or as a disabled widow or widower, and the previous period of disability terminated more than 84 months before reentitlement.

Section 3(c) provides that these amendments apply to medicare protection for months after the month of enactment.

Section 4. Reciprocal Agreements for Services Furnished Outside the United States

Section 4 of the bill amends title XVIII of the Social Security Act by adding at the end thereof a new section 1882 entitled "International Agreements."

The new section 1882 (a) and (b) authorizes the President to enter into agreements establishing reciprocal arrangements between medicare and the comparable or similar program of any foreign country. Any such agreement must specify (1) the nature and extent of payment to be made to or on behalf of entitled individuals; (2) the nature and duration of services for which payment will be made (except that no agreement may authorize any foreign national to receive benefits in the United States on a reciprocal basis in excess of those provided for medicare beneficiaries); (3) such limitations on entitlement of individuals to benefits on a reciprocal basis as the President deems appro-

priate (except that no agreement may provide entitlement to benefits for a foreign national who does not meet medicare's entitlement requirements with respect to age or medical condition); (4) the methods by which the cost of providing services to entitled individuals will be shared by the individuals receiving the services and the respective programs of the United States and the foreign country; and (5) such other provisions, not inconsistent with this section, as the President deems appropriate.

New section 1882(c) authorizes the Secretary of Health, Education, and Welfare to promulgate such regulations and establish such procedures as are reasonable and necessary to implement and administer any agreement entered into under this section.

New section 1882 (d) authorizes the Secretary, pending the conclusion of an agreement under this section, to enter into interim arrangements with any hospital in that country which is accredited by the Joint Commission on Accreditation of Hospitals, or such other hospitals as the Secretary finds meet health and safety standards equivalent to those required by medicare in the United States and which are accredited in the foreign country concerned, under which payment may be made for inpatient hospital services (as defined in section 1861 of the Social Security Act) to or on behalf of medicare beneficiaries. For purposes of making such payment, the Secretary may use any method provided for in section 1814(f) of the Social Security Act, except that such payment shall be reduced to the extent the individual has no legal obligation to pay for the services by reason of the laws of the foreign country in which the hospital is located, or such individual's membership in an insurance plan provides for payment for such services.

Section 5. Dentists' Services

Section 5(a) of the bill amends the present definition of physician in section 1861(r)(2) of the Social Security Act to provide that services performed by a doctor of dental surgery or of dental medicine are covered where such services are covered when performed by a physician as defined in section 1861(r)(1) provided the doctor of dental surgery or of dental medicine is legally authorized to practice dentistry by the State in which he performs such functions and he is acting within the scope of his license.

Section 5(b) amends section 1814(a)(2)(E) of the Social Security Act to provide coverage for inpatient hospital services for the performance of a noncovered dental service where a physician (including a physician as defined in 1861(r)(2)) certifies that not only a patient's underlying medical condition and clinical status but also the severity of the dental procedure itself warrants hospitalization.

Section 5(c) amends section 1862(a)(12) of the Social Security Act by providing that hospital services for the performance of a noncovered dental procedure are not excluded services where the severity of the dental procedure warrants hospitalization.

Section 6. Treatment of Plantar Warts

Section 6 of the bill amends section 1862(a)(13)(C) of the Social Security Act to eliminate warts from the definition of the routine foot care that is excluded as a covered service.

Section 7. Community Mental Health Centers

Section 7(a) amends section 1832(a)(2) of the Social Security Act to include community mental health center services within the scope of benefits under Part B of Medicare.

Section 7(b) amends section 1832(a)(2)(B)(i) to include physician's services furnished to a patient in a community mental health center or a comprehensive outpatient rehabilitation facility within the scope of benefits under Part B of Medicare.

Section 7(c) amends section 1833(c) to exclude mental health services furnished to patients of a community mental health center from the annual limitation on payment for outpatient mental health services.

Section 7(d) amends title XVIII of the Social Security Act by adding a new section 1834, entitled, "Limitation on Community Mental Health Center Services." New section 1834 limits payment for community mental health center services furnished to a beneficiary to 15 outpatient visits and 60 partial hospitalization visits during any calendar year.

Section 7(e) amends section 1835(a)(2) of the Social Security Act by adding a new subparagraph (E), which requires a physician to certify (and recertify), in the case of community mental health center services, that (1) such services were required in connection with the treatment of mental, psychoneurotic, or personality disorder; (2) a plan for furnishing such services has been established by a physician or other mental health professional (as defined for this purpose in regulations by the Secretary) and is periodically reviewed and approved by a physician; (3) such services were furnished while the individual was under the case management of a physician; and (4) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require inpatient psychiatric services.

Section 7(f) amends section 1861(l) of the Social Security Act to extend Medicare provisions relating to agreements for the transfer of patients between skilled nursing facilities and hospitals to such agreements between community mental health centers and hospitals.

Section 7(g) amends section 1861(u) to include community mental health center in the definition of provider of services.

Section 7(h) makes a conforming amendment to section 1861(w)(1), which defines the term "arrangements" for Medicare purpose.

Section 7(i) amends section 1861 of the Social Security Act by adding a new subsection (bb) entitled, "Community Mental Health Center Services."

Paragraph (1) of new subsection (bb) defines the term "community mental health center services" to mean the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations) by others under arrangements with them made by the center—

> (A) Diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician or any qualified mental health professional (as defined in regulations), including clinical psychologists, psychiatric nurses, and psychiatric social workers;

(B) Drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) Such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment; excluding, however, any item or service if it would not be covered if furnished to an inpatie nt of a hospital.

Paragraph (2) of new subsection (bb) defines the term "community mental health center" to mean a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Center Act and the regulations prescribed under such Act;

(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(D) maintains clinical records on all patients;

(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(F) has in effect an agreement with a hospital under section 1861(l) for the transfer of patients;

(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health menters, is licensed pursuant to such law;

(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

Section 7(j) amends section 1864(a) of the Social Security Act to provide for the use of State agencies to determine compliance by community mental health centers with applicable provider conditions of participation.

Section 7(k) provides that the amendments made by section 7 become effective with respect to a community mental health center's first accounting period which begins on or after March 1, 1980.

Section (1) requires the Secretary to submit a report to the Congress recommending a definition of an outpatient mental health center which could be used to broaden the definition of community mental health center as established by the amendments made by section 7.

Section 8. Comprehensive Outpatient Rehabilitation Services

Section 8(a) of the bill amends section 1832(a)(2) of the Social Security Act to include comprehensive outpatient rehabilitation services among the medical and other health services for which payment may be made under medicare part B on behalf of an entitled beneficiary.

Section 8(b) adds to section 1835(a)(2) of the Social Security Act a new subparagraph (F) requiring as a condition of payment for

comprehensive outpatient rehabilitation services that a physician certify that the services were required because the individual needed skilled rehabilitation services, a plan for furnishing such services has been established and is periodically reviewed by a physician, and the services were furnished while the individual was under the care of a physician.

Section 8(c) amends section 1861(u) of the Social Security Act to include comprehensive outpatient rehabilitation facilities within medicare's definition of a provider of services.

Section 8(d) amends section 1861(z) of such Act to require a comprehensive outpatient rehabilitation facility to have an overall plan and budget as described therein.

Section 8(e) adds to section 1861 of the Social Security Act a new section (cc) relating to comprehensive outpatient rehabilitation services and facilities.

Paragraph (1) of new subsection (cc) defines the term "comprehensive outpatient rehabilitation services" as including the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations) to an outpatient of the facility under a plan established and periodically reviewed by a physician: physicians' services; physical therapy, occupational therapy, speech pathology services, and respiratory therapy; prosthetic and orthotic devices including testing, fitting, and training in their use; social and psychological services; nursing care by or under the supervision of a registered professional nurse; drugs and biologicals which cannot be self-administered; supplies, appliances and equipment; and such other medically necessary items and services for rehabilitation of the patient as are ordinarily furnished by such facilities. However, items and services would be excluded if they would not be covered when furnished to a hospital outpatient.

Paragraph (2) of the new subsection (cc) defines the term "comprehensive outpatient rehabilitation facility" as an institution which: is primarily engaged in provding (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons; provides at least physicians' services (by physicians who are available at the facility on a full- or part-time basis), physical therapy, and social or psychological services; maintains clinical records on all patients; has policies established by a professional group including one or more physicians and provides for them to be carried out by a full- or part-time physician associated with the facility; requires that every patient be under the care of a physician; is licensed or meets State or local licensing requirements; has in effect a utilization review plan: has in effect an overall plan and budget that meets the requirements of section 1861(z); and meets such other health and safety conditions as the Secretary may find necessary, including conditions concerning qualifications of personnel.

Section 8(f) amends section 1863 of the Social Security Act to require that, as in the case of other providers, the Secretary of HEW shall, in developing health and safety conditions for comprehensive outpatient rehabilitation facilities, consult with specified governmental and private organizations, and to provide that such conditions may be varied for different areas or different classes of facilities and may,

at the request of a State, be higher for such State than for other States.

Section 8(g) amends section 1864(a) of the Social Security Act to make provision for the use of State agencies to determine compliance with the conditions of participation for comprehensive outpatient rehabilitation facilities.

Section 8(h) provides that the amendments made by section 8 of the bill shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after March 1, 1980.

Section 9. Optometrists' Services

Section 9(a) of the bill amends the definition of physician in 1861(r)(4) of the Social Security Act to provide coverage for services furnished by optometrists related to the treatment of aphakia.

Section 9(b) directs the Secretary to submit to the Congress by June 1, 1980, legislative recommendations with respect to medicare reimbursement for services furnished by optometrists in connection with the treatment of cataracts and with respect to such other services as they are legally authorized to perform.

Section 10. Antigens

Section 10 of the bill amends section 1861(s)(2) of the Social Security Act by adding a new subparagraph (G) to provide coverage for antigens prepared by a physician, for a particular patient, including antigens which are forwarded to another qualified person (including a rural health clinic) for administration to such patient from time to time, by or under the supervision of another physician.

Section 11. Payment Where Beneficiary Not at Fault

Section 11 of the bill amends section 1879 of the Social Security Act by adding at the end thereof a new subsection (e). New subsection (e) provides that where payment for inpatient hospital services or extended care services may not be made under part A of title XVIII of the Social Security Act on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertant, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861(e) or (j) of the Social Security Act by such provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary may take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertant, or erroneous action.

Section 12. Flexibility in Application of Standards to Rural Hospitals

Section 12 of the bill amends section 1861(e) of the Social Security Act (which defines a hospital for medicare purposes) by adding a new sentence at the end thereof, which sentence provides that the term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area specified in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsec-

tion, except that—(A) with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may temporarily waive the requirements for such period as he deems appropriate where (i) there is a temporary shortage of qualified nursing personnel in the area, (ii) a registered nurse is rendering or supervising the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during the temporary period will not adversely affect patient health and safety; (B) with respect to health and safety requirements promulgated under paragraph (9) of this subsection, such requirements are to be applied in such manner as to assure that personnel requirements take into account the availability of technical personnel in the area and the scope of services rendered by the facility, and the Secretary is to provide for the continued participation of such a rural facility where the personnel requirements are not fully met, for such period as he determines that the facility is making good faith efforts to fully comply with the personnel requirements and the employment of such personnel as are available to the facility will not adversely affect patient health and safety; and (C) with respect to fire and safety requirements promulgated under paragraph (9) of this subsection, the Secretary may (i) waive (for such period as he deems appropriate) specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for the facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9) if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

Section 13. Certification and Utilization Review by Podiatrists

Section 13(a) of the bill amends section 1861(r) of the Social Security Act (which defines the term "physician" for purposes of medicare) by modifying the definition in paragraph (3), relating to podiatrists. For purposes of medicare coverage, a doctor of podiatric medicine is a physician with respect to functions he is legally authorized to perform as such by the State in which he performs them. In addition, a doctor of podiatric medicine is defined as a physician for purposes of sections 1814(a) and 1835 of the Social Security Act (relating to physician certifications) and subsections (k) (relating to utilization review) and (m) (relating to the requirement that a home health patient be under the care of a physician) of section 1861; for such purposes, the definition extends only to functions that are consistent with the scope of podiatric practice in the State where the doctors of podiatric medicine performs them and that are consistent with the policies of any health care institution involved.

Section 13(b) amends section 1861(k)(2)(A) of the Social Security Act to provide that, although a doctor of podiatric medicine may serve as a physician member of a hospital or skilled nursing facility utilization review committee, such a committee must also have two physician members who are either doctors of medicine or doctors of osteopathy.

Section 14. Physician Treatment Plan for Speech Pathology

Section 14 of the bill amends section 1835(a)(2)(D)(ii) of the Social Security Act to allow a physician or the speech pathologist providing the speech pathology services to establish the plan of treatment required by this section.

Section 15. Payment for Physicians' Services Where Beneficiary Has Died

Section 15 of the bill amends section 1870(f) of the Social Security Act to provide for reimbursement for physicians' services where the beneficiary has died, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physicians' services. Alternative procedures for payment contained in 1870(f) are retained under this amendment.

Section 16. Presumed Coverage Provisions

Section 16 of the bill repeals section 1814(h) and (i) of the Social Security Act pertaining to presumed coverage for certain care provided in skilled nursing facilities and certain care provided by home health agencies and redesignates the remaining subsection accordingly.

Section 17. Payment to Providers of Services

Section 17(a) of the bill amends section 1814(b) of the Social Security Act to provide that (except for reimbursement for certain services to renal disease patients) Medicare reimbursement under Part A to providers of services will (subject to deductible and coinsurance provisions) be on the basis of reasonable cost as determined under section 1861(v) of the Social Security Act. Subsection (a) of the bill repeals the provisions of existing law under which payment to a provider is limited to the provider's customary charges if these charges are lower than reasonable costs.

Section 17(b) amends sections 1833(a) of the Social Security Act (relating to reimbursement under part B) by striking out paragraphs (2) and (3) and inserting new paragraphs (2), (3), (4), and (5).

New paragraph (2) provides (subject to any unsatisfied deductible amounts) for reimbursement to providers of services based on the reasonable costs of covered services (as determined under section 1861 (v) of the Social Security Act) less any coinsurance amounts the provider is authorized to charge beneficiaries (as described in clause (ii) of section 1866(a)(2)(A)) but in no case may the amount reimbursed exceed 80 percent of the reasonable cost of the services. This provision does not apply to rural health clinic services, community mental health center services, comprehensive outpatient rehabilitation services, facility services furnished in connection with certain ambulatory surgical procedures (added by section 28 of the bill), and certain preadmission diagnostic services described in new paragraph (5).

The new paragraph (2) also restates, without substantive change, the existing rule for reimbursement to independently practicing physical therapists.

In similar fashion, new paragraph (3) provides, with respect to rural health clinic, community mental health center, and comprehensive outpatient rehabilitation services, for coinsurance amounts to be offset against costs; except that in the case of such clinics, centers, and facilities, the costs involved are amounts which are reasonable and related

to the cost of furnishing covered services or based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under Section 1861(v)(1)(A) of the Social Security Act.

New paragraph (4) provides for reimbursement of facility services furnished in connection with certain ambulatory surgical procedures at an amount established by the Secretary for the procedure under new sections 1833(i)(2)(A) and 1833(i)(2)(B) which are added by sections 28 of the bill.

New paragraph (5) provides for reimbursement of the reasonable cost of preadmission diagnostic services furnished by the outpatient department of a hospital within 7 days of the beneficiary's admission as a hospital inpatient.

Section 17(c) of the bill provides that the amendments made by this section shall be effective with respect to services provided on or after January 1, 1980.

Section 18. Limit on Premium Increases Due to Late Enrollment

Section 18 of the bill amends section 1839(d) of the Social Security Act by limiting the premium increase for late enrollment provided for in the subsection to 30 percent.

Section 19. Reenrollment in Part B

Section 19 of the bill repeals section 1837(b) of the Social Security Act which limited reenrollment in part B of the program.

Section 20. Chiropractors Services

Section 20(a) of the bill amends section 1861(r)(5) of the Social Security Act to provide coverage for services furnished by chiropractors for manipulation of the spine where the existence of sublaxation of the spine can be demonstrated by an X-ray or other chiropractic clinical findings.

Section 20(b) amends section 1861(s)(3) by adding a new subparagraph (B) that includes diagnostic X-ray tests which are furnished by a chiropractor and which are reasonable and necessary in the diagnosis of a sublaxation of the spine in the definition of covered medical and other health services.

Section 21. Increase in Outpatient Mental Health Benefits Under Part B

Section 21(a)(1) of the bill amends section 1833(c) of the Social Security Act to increase the limit on Part B payments for the treatment of mental, psychoneurotic, or personality disorders of individuals who are not hospital inpatients to 80 percent of reasonable charges, not to exceed $750 (80 percent of $937.50) in any calendar year.

Section 21(a)(2) makes a conforming amendment to section 1866(a)(2)(A), relating to agreements with providers of services.

Section 21(a)(3) provides that these amendments apply to expenses incurred in calendar years beginning after the date of enactment.

Section 21(b)(1) amends section 1861(r) (which defines the term "physician" for purposes of Medicare) by adding a new clause (b), which provides for coverage of services furnished to an individual who is not a hospital inpatient by a clinical psychologist who is licensed by the State (or otherwise legally authorized to perform clinical psychologist's services) and who meets uniform minimum require-

ments prescribed by the Secretary if the following conditions are met: (1) the individual is referred to the psychologist by a physician; (2) the individual is receiving such services in connection with the treatment of mental, psychoneurotic, or personality disorders; and (3) the services are those which the clinical psychologist is legally authorized to perform.

Section 21(b)(2) amends section 1835(a)(2)(B), (relating to physician certification and recertification) by adding a new clause which requires, in the case of covered services furnished to an outpatient by a clinical psychologist, the clinical psychologist to certify and recertify that the services are required for the treatment of mental, psychoneurotic, or personality disorders.

Section 22. Limitation on Payments to Radiologists and Pathologists

Section 22(a) amends subsections (a)(1)(B) and (b)(2) of section 1833 of the Social Security Act (relating to payment of Part B benefits) to limit reimbursement for inpatient radiological and pathological services at 100 percent of reasonable charges (with no deductible) to those radiologists and pathologists who agree to accept assignment for all services furnished to hospital inpatients enrolled under Part B.

Section 22(b) provides that the amendments made by section 22(a) apply to services furnished after the sixth calendar month beginning after enactment.

Section 23. Shortened Part B Termination Period for Certain Individuals Whole Premiums Medicaid Has Ceased to Pay

Section 23(a) amends section 1843(e) of the Social Security Act by adding a new sentence that requires the Part B coverage period of an individual who (in the last month of his coverage under a state buy-in agreement or in any of the following 6 months) files notice that he no longer wishes to participate in the Part B program, to terminate at the end of the month in which the notice is filed.

Section 23(b) specifies a technical conforming amendment to section 1838(b).

Section 23(c) specifies a technical conforming amendment to section 1843(g)(2).

Section 23(d) provides that the amendments made by section 23 apply to notices filed after the third calendar month after enactment.

Section 23(e) requires the coverage period under Part B of an individual whose coverage under a State buy-in-agreement is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of the bill that he no longer wishes to participate in the Part B program to terminate on the earlier of (1) the day specified in section 1838 without the amendments made by section 23, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of enactment.

Section 24. Outpatient Physical Therapy Services

Section 24(a) amends section 1833(g) of the Social Security Act, as added by section, 251(a)(2) of Public Law 92–603, to increase the limit on expenses incurred in any calendar year for certain outpatient

physical therapy services provided by independently practicing physical therapists from $1000 to $500.

Section 24(b) redesignates section 1833(g), as added by section 279(b) of Public Law 92–603, as section 1833(h).

Section 25. Reimbursement for Blood

Section 25(a) repeals the following provisions:

(1) Paragraph (2) of section 1813(a) (Part A Blood deductible);

(2) The last sentence of section 1833(b) (Part B blood deductible);

(3) Section 1866(a)(2)(C) (provider agreements provision relating to charges for blood).

Section 25(b) amends section 186(v)(1)(A) (which defines the term "reasonable cost") by inserting a new clause that requires the Secretary's reasonable cost reimbursement regulations to take into account the customary practices of providers of services in the replacement of blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to a beneficiary, except that adjustments may be made to assure compliance with the reimbursement principles set forth in section 1861(v).

Section 26. Medicare Payment Liability Secondary in Certain Automobile Insurance Cases

Section 26 amends section 1862(b) of the Social Security Act (relating to exclusions from coverage) to: (1) prohibit Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made under an automobile insurance policy; and (2) provide that Medicare payment for such items or services must be conditioned on reimbursement to the appropriate Medicare trust fund when notice is received that payment has been made under an automobile insurance policy.

Section 27. Hospital Transfer Requirement for Skilled Nursing Facility Coverage

Section 27 amends section 1861(i) to: (1) increase the period within which a beneficiary must be transferred from a hospital to a skilled nursing facility in order to qualify for post-hospital extended care benefits from 14 days (28 days if there is a shortage of appropriate bed space in the area) to 30 days after the discharge from the hospital; and (2) increase the period following discharge from a skilled nursing facility within which the beneficiary can be readmitted to a skilled nursing facility without again meeting the 3-day prior hosptalization requirement from 14 days to 30 days.

Section 28. Outpatient Surgery

Section 28(a) amends section 1832(a) by adding a new subparagraph (G) that covers under Part B facility services furnished in connection with certain surgical procedures specified by the Secretary and performed in an ambulatory surgical center which meets health, safety, and other standards specified in regulations.

Section 28(b) adds to section 1833 of the Social Security Act a new subsection (i), relating to surgical procedures performed on an ambulatory basis.

Paragraph (1) of new subsection (i) requires the Secretary, in consultation with the National Professional Standards Review Council

and appropriate medical organizations, to specify surgical procedures which are appropriately (when considered in terms of proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital, but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or a hospital outpatient department.

Paragraph (2)(A) of new subsection (i) requires payment for facility services furnished in connection with a specified surgical procedure performed in an ambulatory surgical center or hospital outpatient department to be equal to an amount that takes into account the costs incurred by such centers (or classes of centers) generally in providing the services and assures that the performance of the service in such an ambulatory surgical center or hospital outpatient department will result in substantially less amounts paid under Medicare than would have been paid if the services had been furnished on an inpatient basis.

Paragraph (2)(B) of new subsection (i) further provides for appropriate adjustments to the payment rate.

Paragraph (2)(B) of new subsection (i) requires the amount of payment for physician's services and services incident to a physician's services (including all pre- and post-operative services) furnished in connection with the specified surgical procedures to be the reasonable charge for such services if the physician accepts assignment.

Section 28(c) amends section 1835(a)(2) by adding a new subparagraph (G), which requires a physician to certify (and recertify) that services furnished in connection with a specified surgical procedure in an ambulatory surgical center are or were medically required.

Section 28(d) amends section 1861(u) to include ambulatory surgical center in the definition of provider of services.

Section 29. Technical Renal Disease Amendment

Section 29(a) amends section 1881(e) of the Social Security Act to specify that the Secretary enter into agreements with nonprofit entities for reimbursement of the reasonable cost (without regard to deductibles and coinsurance) of dialysis equipment economically and efficiently furnished to beneficiaries who dialyze at home.

Section 29(b) amends section 1881(g) of the Social Security Act to change the date on which the Secretary is required to submit to the Congress a report on the end stage renal disease program from April 1 to July 1 of each year.

Section 30. Preadmission Diagnostic Testing

Section 30(a) amends section 1833(a)(1) of the Social Security Act by adding a new subparagraph (F) relating to preadmission diagnostic radiological or pathological services for which payment may be made under Part B and which are furnished to an individual by the outpatient department of a hospital within 7 days of the individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations), to another hospital by a physician in the field of radiology or pathology. New subparagraph (F) requires payment of the reasonable charges for such services if the physician agrees to accept an assignment for all physicians' services furnished by him to Medicare beneficiaries.

Section 30(b) requires the Secretary to report to Congress no later than one year after the date of enactment of the bill describing the policy which has been developed and implemented with respect to the amendments made by section 30(a) and section 17(b) of the bill as they concern payment for preadmission diagnostic testing furnished to an individual at a hospital within 7 days of an individual's admission to another hospital.

Section 31. Studies and Demonstration Projects

Section 31(a) requires the Secretary to develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

Section 31(b) requires the Secretary to submit to the Congress, within one year after the date of enactment, a report (including any legislative recommendations) on the demonstration projects being conducted on the waiver of the applicable cost-sharing amounts which Medicare beneficiaries have to pay for obtaining a second opinion on having surgery performed.

Section 31(c) requires the Secretary to conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

Section 31(d) requires the Secretary to develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

Section 31(e) requires the Secretary to conduct, in consultation with appropriate professional organizations, a comprehensive study of methods for providing coverage under Part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling conditions who require special fitting considerations or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary is directed to submit to Congress, no later than January 1, 1981, a report on the findings of this study and such specific legislative recommendations as appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

Section 31(f) requires the Secretary to conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

Section 31(g) requires the Secretary to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

Section 31(h) directs the Secretary to submit a report (including any legislative recommendations) on each of the demonstration projects and studies described in subsections (a), (c), (d), (f), and (g) of

section 31 of the bill, and requires each report to be submitted within 24 months of the date of enactment.

Section 31(i) requires grants, payments under contracts, and other expenditures made for studies and demonstration projects under section 31 to be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act).

Section 32. Provider Reimbursement Review Board

Section 32 amends section 1878(f)(1) of the Social Security Act to specify the right of providers to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider) that it is without authority to decide the question, by a civil action commenced within 60 days of the date on which the Board's determination is rendered. The Board is required to render a determination requested by a provider within 30 days of the date of the request, and such determination is not subject to review by the Secretary.

Section 33. Access to books and records of subcontractors

Section 33 of the bill amends section 1861(v)(1) of the Social Security Act by adding a new subparagraph (H), which prohibits Medicare reimbursement for amounts incurred by providers under contracts for services unless such contracts contain a provision allowing the Secretary and the Comptroller General to have access (for three years following the date such services are furnished) to the books, records, and papers of the contractor that are directly related to the contract. This provision applies to services furnished pursuant to contracts entered into by the provider after the date of enactment of the bill.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Sec. 226.
(a) * * *

* * * * * * *

(b) Every individual who—

(1) has not attained age 65, and

(2) (A) is entitled to, and has for 24 [consecutive] calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or (B) is, and has been for not less than 24 [consecutive] months a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth [consecutive] month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65.

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, [and post-hospital home health services] *and home health services* (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services [or post-hospital home health services] unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

* * * * * * *

(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before that particular month in any case where such monthly benefits were of the type specified in clause (A) (i) or (B) of subsection (b) (2), or

(2) more than 84 months before that particular month in any case where such monthly benefits were of the type specified in clause (A) (ii) or (A) (iii) of such subsection.

shall not include any month which occurred during such previous period.

[(f)] *(g)* For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part A—Hospital Insurance Benefits for the Aged and Disabled

DESCRIPTION OF PROGRAM

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital [and related post-hospital services], *related post-hospital, and home health services in* accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system; (2) individuals under age 65 who have been entitled for not less than 24 [consecutive] months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability; and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d) (2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

[(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.]

(3) home health services.

* * * * * * *

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections [(b), (c), and (d)] *(b) and (c)* inpatient hospital services, inpatient psychiatric hospital services, [post-hospital extended care services, and post-hospital home health services] *and post-hospital extended care services* shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illnes.]

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may be regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition

requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of [post-hospital] home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy [, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services]; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such [dental] services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital

or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861 (k)(4). including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than June 30, 1980, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

Amount Paid to Providers

[(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

[(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services; or

[(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.]

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1818(b)(2)(B).

No Payments to Federal Provisers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection [(j)] (*h*)) *to any* Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * * * *

[Payment for Posthospital Extended Care Services

[(h)(1) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

[(A) the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations,

[(C) such certification is accompanied by a plan of treatment for providing such services, and

[(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

[Payment for Posthospital Home Health Services

[(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

[(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

[(C) there is compliance with such other requirements and procedures may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).]

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

[(j)](*h*)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

* * * * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1818. (a) * * *

* * * * * * *

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of provides of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may *(subject to the provisions of paragraph (4))* designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to the other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency

and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, [or]

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, [and] *or*

(III) a physician to a patient in a community mental health center or to a patient in a comprehensive outpatient rehabilitation facility; and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; [and]

(D) rural health clinic services[.]*;*

(E) community mental health center services;

(F) comprehensive outpatient rehabilitation facility services; and

(G) facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations).

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayament basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology *who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for hospital inpatients enrolled under this part*, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred, for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), [and] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, *and (F) with respect to expenses incurred for preadmission diagnostic radiological or pathological services for which payment may be made under this part and which are furnished to an individual by the outpatients department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital by a physician in the field of radiology or pathology who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for such services to individuals enrolled under this part, the amounts paid shall be equal to the reasonable charges for such services*, and

[(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraph (D) of section

1832(a)(2))"—with respect to home health services, 100 percent, and with respect to other services (unless otherwise specified in section 1881), 80 percent of—

[(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

[(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

[(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services, and

[(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A).]

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F), and (G) of such section and in pargaraph (5) of this subsection)—

(A) with respect to home health services, the reasonable cost of such services, as determined under section 1861(v);

(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(3) in the case of services described in subparagraphs (D), (E), and (F) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such costs; and

(4) in the case of facility services described in subparagraph (G) of section 1832(a)(2), the applicable amount described in subparagraph (A) of section 1833(i)(2); and

(5) in the case of preadmission diagnostic services described in section 1866(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology *who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all pysicians' services furnished by him for hospital inpatients enrolled under this part, and (3) such deductible shall not apply with respect to home health services.* [The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.]

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital *and not a patient of a community mental health center* at the time such expenses are incurred, [there] *not more than $937.50 shall be considered as incurred* expenses for purposes of subsections (a) and (b) [only whichever of the following amounts is the smaller:

[(1) $312.50, or

[(2) 62½ percent of such expenses.]

* * * * * * *

(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than [($100] *$500 shall be considered as incurred* expenses for purposes of subsections (a) and (b).

[(g)] (*h*) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to

the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.

(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or hospital outpatient department.

(2)(A) The amount of payment to be made for facility services furnished in connection with surgical procedures specified pursuant to paragraph (1) and furnished to an individual in an ambulatory surgical center shall be equal to an amount established by the Secretary with respect to each such procedure which (i) takes into account the costs incurred by such centers, or classes of centers, generally in providing the services appropriate for the performance of such services, and (ii) takes such costs into account in such a manner which will assure that the performance of the service in such an ambulatory surgical center will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis. The amount so established shall be reviewed periodically and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in an ambulatory surgical center or a hospital outpatient department shall be the reasonable charge for such services if the physician accepts an assignment, as provided for in section 1842(b)(3)(B)(ii), with respect to such payment.

[LIMITATION ON HOME HEALTH SERVICES

[SEC. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during each year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

LIMITATION ON COMMUNITY MENTAL HEALTH CENTER SERVICE

SEC. 1834. Payment under this part may be made for community mental health center services furnished an individual for—

(1) up to 15 outpatient visits during any calendar year; and

(2) up to 60 partial hospitalization visits to such a center during any calendar year.

Services shall be taken into account for purposes of paragraphs (1) and (2) only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services under this part.

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832 (a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B)(*i*) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; [and]

(ii) in the case of services furnished by a physician described in section 1861(r)(6) to an individual described in such section, such services are or were required for the treatment of mental psychoneurotic, or personality disorders;

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established *by a physician or by the speech pathologist providing such services* and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]*;*

(E) in the case of community mental health center services, (i) such services are or were required in connection with the treatment of mental, psychoneurotic, or personality disorders, (ii) a plan for furnishing such services has been established by a physician (as defined in section 1861(r)(1)) or other mental health professional (as defined for this purpose in regulations by the Secretary) and is periodically reviewed and approved by a physician, (iii) such services are or were furnished while the individual is or was under the case management of a physician (as defined in section 1861(r)(1)), and (iv) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require or have required (in the professional judgment of such physician) inpatient psychiatric services;

(F) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(G) in the case of services furnished in connection with surgical procedures, specified pursuant to section 1833(i)(1), in an ambulatory surgical center, such services are or were medically required.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined).

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) No individual may enroll under this part more than twice.]

* * * * * * *

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th [consecutive] month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occured in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

* * * * * * *

COVERAGE PERIOD

SEC. 1838. (a) * * *

(b) An individual's coverage period shall (*except as otherwise provided in section 1843(e)*) continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause

for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837(b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

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(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled*; except that in no case may the total amount of such increase exceed 30 percent of such monthly premium so determined.* For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) * * *

* * * * * * *

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837

in the initial general enrollment period provided by section 1837(c). *The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.*

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), *and*

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection [, and].

[(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such individual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month).]

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Part C—Miscellaneous Provisions

definition of services, institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and [subsections (i) and (n)] *subsection (i)* of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of

injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an instituion in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and [subsections (i) and (n)] *subsection (i)* of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical

diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. *The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—*

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the per-

sonnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

* * * * * * *

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an in individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility—

(A) within [14] *30* days after discharge from such hospital [, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C)], *or (B)* within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within [14] *30* days after discharge from a hospital;

an individual shall be deemed not to have been discharged from a skilled nursing facility if, within [14] *30* days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

* * * * * * *

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the

purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made either (A) a staff committee of the institution composed of two or more physicians (*of which at least two must be physicians described in subsection (r) (1) of this section*), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

* * * * * * *

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility *or community mental health center* shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility *or community mental health center* whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility *or community mental health center* which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of the patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such

items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide *who has successfully completed a training program approved by the Secretary;*

* * * * * * *

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z); [and]

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; *and*

(7) *meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Sec-*

retary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

[except that] *regulations; and* such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

* * * * * * *

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of [dentistry or of dental or oral surgery] *dental surgery or of dental medicine* who is legally authorized to practice dentistry by the State in which he performs such function [but only with respect to (A) surgery related to the jaw or any structure continguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act] *and who is acting within the scope of his license when he performs such functions,* [(3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,] *(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions* which he is legally authorized to perform, [or] (4) a doctor of optometry, who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to [establishing the necessity for prosthetic lenses] *services related to the treatment of aphakia,* [or] (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray *or other chiropractic clinical findings* to exist) which he is legally authorized to perform

by the State or jurisdiction in which such treatment is provided, *or* (*6*) *a clinical psychologist who is licensed as such by the State* (*or in a State which does not license clinical psychologists as such, is legally authorized to perform the services of a clinical psychologist in the jurisdiction in which he performs such services*) *and who meets uniform minimum requirements prescribed by the Secretary, but only for the purpose of section 1861*(*s*)(*1*) *and section 1835*(*a*)(*2*)(*B*)(*ii*) *and only with respect to the treatment of an individual who is not an inpatient of a hospital* (*as defined in subsection* (*e*) *or* (*f*) *of this section*), *was referred to the psychologist by a physician described in clause* (*1*), *and is receiving such services in connection with the treatment of mental, psychoneurotic, or personality disorders and only with respect to services which such clinical psychologist is legally authorized to perform by the State or jurisdiction in which such services are furnished.* For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; *and*

(*G*) *antigens* (*subject to quantity limitations prescribed in regulations by the Secretary*) *prepared by a physician, as defined in section 1861* (*r*)(*1*), *for a particular patient, including antigens so prepared which are forwarded to another qualified person* (*including a rural health clinic*) *for administration to such*

patient, from time to time, by or under the supervision of another such physician;

(3) (*A*) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(B) diagnostic X-ray tests which are furnished by a physician described in subsection (r) (5) and which are reasonable and necessary in the diagnosis of a subluxation of the spine;

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Provider of Services

(u) The term "provider of services" means a hospital, *ambulatory surgical center*, skilled nursing facility, *comprehensive outpatient rehabilitation facility*, home health agency, *community mental health center*, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v) (1) (A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the

methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, [and] (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive, *and (iii) take into account the customary practices of providers of services in the replacement of blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to an individual with respect to whom payment may be made under this title, except that, notwithstanding such practices, such adjustments as are necessary to assure compliance with the principles set forth in this subsection (and regulations pursuant thereto) shall be made in determining such costs.*

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B) (i) and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such

hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(e) Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing provisions of this subparagraph shall not apply to any skilled nursing facility in such State if—

(i) such facility is a distinct part of or directly operated by a hospital, or

(ii) such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of the costs determined by the application of this subparagraph (without regard to such clause (ii)).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

(iv) in the case of contracts entered into by a home health agency before the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(H) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any service furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that the Secretary and the Comptroller General of the United States (or any of his duly authorized representatives) shall, until the expiration of three years after the furnishing of such service pursuant to such contract, have access to and the right to examine (for purposes of audit and transcription) any directly related pertinent books, documents, papers, and records of such subcontractor.

Arrangements for Certain Services

(w) (1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, *community mental health center*, or home health agency (whether in its own right or as agent) with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

* * * * * * *

Institutional Planning

(z) An overall plan and budget of a hospital, [extended care facility,] *skilled nursing facility*, *comprehensive outpatient rehabilitation facility*, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of

$100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

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Community Mental Health Center Services

(bb) (1) The term "community mental health center services" means the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations by the Secretary) by others under arrangements with them made by the center—

(A) diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician (as defined in subsection (r) (1)) or any qualified mental health professional (as defined by the Secretary in regulations), including clinical psychologists, psychiatric nurses, and psychiatric social workers;

(B) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(2) The term "community mental health center" means a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Centers Act and the regulations prescribed thereunder;

(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(D) maintains clinical records on all patients;

(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(F) has in effect an agreement with a hospital pursuant to subsection (1);

(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

Comprehensive Outpatient Rehabilitation Facility Services

(cc) (1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved

by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) * * *

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(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns[, warts,] or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State *or under an automobile insurance policy*. Any payment under this title with respect to any item or services shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan *or policy*.

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CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsec-

tions (e)(9), (f)(4), (g)(4), (j)(11), and (o)(6) *(o)(6), and (cc)(2)(I)* of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), *or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)*, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861 (s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), *or whether a facility therein is a community mental health center as defined in section 1861(bb)(2)*. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, or home health agency, *or a community mental health center* (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services(which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, *com-*

prehensive outpatient rehabilitation facility, laboratory, *community mental health center*, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major addition conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization.

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

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(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). [In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section.]

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[(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined) and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, so as defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

[For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual

with respect to which a deduction is imposed under section 1813 (a)(2).]

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OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. (a) * * *

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[(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

[(1) no assignment of the right to payments was made by such individual before his death, and

[(2) payment for such services has not been made,

payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

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PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 1878. (a) * * *

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(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the

Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. *Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within 30 days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within 60 days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.* Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

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LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

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(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

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MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

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(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services [and], renal dialysis facilities, *and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently*, reimburse such providers [and facilities] , *facilities, and nonprofit entities* (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider [or facility will] , *facility, or other entity will*—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

* * * * * * *

(g) The Secretary shall submit to the Congress on [April] *July* 1, 1979, and [April] *July* 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, nationally and by renal disease network, on dialysis (self-dialysis or otherwise) at home and in facilites;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures;

(7) the range of costs of kidney acqisitions, by type of facility and by region;

(8) the number of facilities providing transplants and the number of transplants performed per facility;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments;

(14) information on the activities of medical review boards and other networks organizations; and

(15) estimated program costs over the next five years.

INTERNATIONAL AGREEMENTS

SEC. 1882. (a) The President is authorized to enter into agreements establishing reciprocal arrangements between the programs established by this title and the program of any foreign country under which similar services are provided directly to entitled individuals or under which insurance is provided to meet all or part of the expenses of entitled individuals for such services.

(b) Any agreement establishing such a reciprocal arrangement pursuant to this section shall specify—

(1) the nature and extent of payment to be made to or on behalf of (A) individuals entitled to benefits under this title for services covered under such title when such individuals are present in the foreign country and receive such services from persons who are authorized under the program of that foreign country to furnish them, and (B) individuals entitled to benefits under the program of that foreign country who receive such services in the United States from persons meeting such requirements or conditions as are required under such title;

(2) such limitations on the nature and duration of services for which payment may be made in one country to individuals entitled to benefits under the program of the other country, as the President deems appropriate, except that no agreement shall authorize any individual to receive benefits in the United States on a reciprocal basis in excess of those provided for individuals entitled to benefits under this title;

(c) such limitations on entitlement of individuals to benefits on a reciprocal basis under an agreement in the United States and in the foreign country, as the President deems appropriate, except that no agreement shall provide entitlement to benefits under this title in the United States for an individual who does not meet the requirements for entitlement applicable under such title with respect to age or medical condition;

(4) the methods by which the cost of providing services to persons on a reciprocal basis shall be shared equitably by the persons receiving such services and by the respective programs of the United States and the foreign country; and

(5) such other provisions, not inconsistent with this section, as the President deems appropriate.

(c) The Secretary shall make rules and regulations and establish procedures which are reasonable and necessary to implement and ad-

minister any agreement which has been entered into in accordance with this section.

(d) Pending the conclusion of an agreement under this section with a foreign country, the Secretary is authorized to enter into interim arrangements with any hospital in that country which is accredited by the Joint Commission on Accreditation of Hospitals, or such other hospitals as the Secretary finds meet health and safety standards equivalent to those required under this title for hospitals in the United States and which are accredited in the foreign country concerned, under which payment may be made for inpatient hospital services, as defined in section 1861, to or on behalf of an individual who is entitled to such benefits under part A of this title. For purposes of making payment under such an interim arrangement, the Secretary shall use whichever of the methods provided for in section 1814(f) he finds appropriate, except that any payments made under part A of this title to the individual or to the hospital shall be reduced to the extent that the individual has no legal obligation to pay for any items or services furnished to such individual by reason of the laws of the foreign country in which the hospital is located or such individual's membership in an insurance plan that provides for payment for such items or services.

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SECTION 7 OF THE RAILROAD RETIREMENT ACT OF 1974

POWERS AND DUTIES OF THE BOARD

SEC. 7. (a) * * *

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(d)(1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, posthospital extended care services, [posthospital] home health services, and outpatient hospital diagnostic services (all hereinafter referred to as "services") under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such sections and such parts apply. For purposes of section 8, a determination with respect to the rights of an individual under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

(2) Except as otherwise provided in this subsection, every person who—

(i) has attained age 65 and (A) is entitled to an annuity under this Act or (B) would be entitled to such an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service; or

(ii) has not attained age 65 and (A) has been entitled to an annuity under section 2 of this Act, or under the Railroad Retire-

ment Act of 1937 and section 2 of this Act, or could have been includible in the computation of an annuity under section 3(f)(3) of this Act, for not less than 24 [consecutive] months and (B) could have been entitled for 24 [consecutive] calendar months, and could currently be entitled, to monthly insurance benefits under section 223 of the Social Security Act or under section 202 of that Act on the basis of disability if service as an employee after December 31, 1936, had been included in the term "employment" as defined in that Act and if an application for disability benefits had been filed,

shall be certified to the Secretary of Health, Education, and Welfare as a qualified railroad retirement beneficiary under section 226 of the Social Security Act.

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